Mental Health Policy in Scotland, 1908-1960

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I declare that this thesis has been composed by me and that it is my own work.

Abstract

This thesis traces the evolution of the Scottish mental health service from one which was almost exclusively concerned with 'lunatics', which was rooted in compulsory committal and detention, and which was linked to a deterrent Poor Law to one which incorporated those suffering from a wide range of mental disturbances, which was largely based on treatment willingly undertaken and freely available, and which was associated with a preventive N.H.S. It examines the concepts and intentions which underlay policy, and the impact of policy upon the service and its clients. It describes the ways in which the service was moulded by the changing and sometimes conflicting demands of the needs of the mentally disordered and of society as a whole. It describes the shifting responses of policy-makers, psychiatrists, the public and patients to perennial questions like the respective roles of compulsion and voluntaryism, containment and active treatment, government and private initiative, hospital and community care, as well as reaction to more dramatic events like wars and major legislative upheavals. The first part of the thesis describes the state of the lunacy service in the early years of the century, the origins and birth of the mental deficiency service, and the impact upon both services of the first total war. The second part deals with the developments of the 1920s and 1930s. It considers the influence of legal and administrative reforms, the increasing emphasis upon the early detection and treatment of deviation from the norm and the growth of a variety of extra-institutional facilities, as well as the therapeutic innovations and disappointments of the inter-war period. The third and final part primarily focuses upon the creation

and subsequent development of the N.H.S. mental health service. It describes the changing face of the hospital service, the further expansion of community care and the post-1945 development of special education for the mentally handicapped, and ends with an analysis of the genesis and significance of the 1960 Act which embodied the new principle of informality.

Contents

Tables

Abbreviations

(Common abbreviations are not listed below: some which are listed are used only in footnotes or the bibliography and not in the main text.)

A.A.S.S.	Aberdeen Association of Social Service
A.C.E.S.	Advisory Council on Education in Scotland
A.D.E.S.	Association of Directors of Education in Scotland
B.H.A.	British Hospitals Association
B.J.E.P.	British Journal of Educational Psychology
B.M.A.	British Medical Association
B.O.M.	Board of Management
C.N.R.	Civil Nursing Reserve
D.H.S.	Department of Health for Scotland
D.R.O.	Disablement Resettlement Officer
E.C.T.	Electro-Convulsive Therapy
E.H.S.	Emergency Hospital Scheme
E.I.S.	Educational Institute of Scotland
E.M.S.	Emergency Medical Service
E.S.N.	Educationally Sub-Normal
F.O.R.A.K.	Friends of the Royal and Kingseat Hospitals
G.B.C.L.S.	General Board of Commissioners in Lunacy for Scotland
J.H.B.	Joint Hospital Board
J.O.C.	Junior Occupation Centre
L.A.	Local Authority
L.A.A.L.C.	Local Authority Associations' Liaison Committee
L.C.C.	Local Care Committee
L.E.A.	Local Education Authority
L.H.A.	Local Health Authority
L.V.A.	Local Voluntary Association
M.H.O.	Mental Health Officer
M.O.H.	Ministry of Health
M.W.C.	Mental Welfare Commission
N.A.B.	National Assistance Board
N.A.W.U.	National Asylum Workers' Union
N.H.S.	National Health Service
N.L.S.	National Library of Scotland

O.T.	Occupational Therapy
P.L.L.G.M.	Poor Law and Local Government Magazine
P.S.W.	Psychiatric Social Worker
R.H.A.C.	Regional Hospital Advisory Council
R.H.B.	Regional Hospital Board
S.A.C.	Standing Advisory Council
S.A.C.C.	Scottish Association of Care Committees
S.A.C.W.H.P.	Scottish Advisory Council for the Welfare of Handicapped Persons
S.A.M.H.	Scottish Association for Mental Hygiene (1938-49)/ Health (1949 onwards)
S.A.M.W.	Scottish Association for Mental Welfare
S.A.P.H.C.	Scottish Association of Parents of Handicapped Children
S.B.H.	Scottish Board of Health
S.C.G.C.	Scottish Child Guidance Council
S.C.R.E.	Scottish Council for Research in Education
S.C.S.S.	Scottish Council of Social Service
S.E.D.	Scottish Education Department
S.E.R.H.B.	South-Eastern Regional Hospital Board
S.H.H.D.	Scottish Home and Health Department
S.H.M.O.	Senior Hospital Medical Officer
S.H.S.C.	Scottish Health Services Council
S.M.A.C.	Standing Medical Advisory Council
S.O.C.	Senior Occupation Centre
S.R.O.	Scottish Record Office
S.S.P.C.C.	Scottish Society for the Prevention of Cruelty to Children
V.A.M.H.	Voluntary Association for Mental Health
W.R.H.B.	Western Regional Hospital Board
Y.E.S.	Youth Employment Service

Introduction

The history of Scottish mental health policy is both the history of changes which took place in one country and the history of developments which took place within one part of a wider unit. Scotland was not isolated from the processes which occurred on a United Kingdom-wide - or wider - stage and nor was it autonomous. The questions upon which attention was between 1908 and 1960 focused - questions like the balance which should be struck between the liberty of the individual and the perceived well-being and security of society generally, between institutional treatment and community care and between the role of the statutory and voluntary sectors - were not confined to Scotland, and the extent to which legislative power was centred on Westminster meant that sometimes the answers which were found were very similar to those found for England.

However, Scotland was, in almost every sense, a very different country from England. Geographically it was smaller with a smaller population which was so sharply divided on regional lines that it is almost impossible to discuss 'a' mental health service. Scotland also had different legal, administrative, political, educational and cultural traditions and structures, and these differences were inevitably reflected in the mental health service. The dissimilarities were maintained and in some cases accentuated by the changes which took place in Scotland and in England in the period 1908-60. There has been some work on the Scottish mental health service; Rice's academic work on the nineteenth-century lunacy service,[1] a primarily medical account of the service by Henderson,[2] and some studies of individual hospitals (notably Easterbrook's monumental history of the

Crichton Royal Institution).[3] But the uniqueness of much of the Scottish experience has too often been ignored or minimised in accounts which, whether implicitly or explicitly, deal with U.K. policy primarily from the English perspective. This thesis tries to reduce a little of the imbalance by describing the ways in which, on the one hand, Scotland's mental health service was peculiarly Scottish and on the other hand the way in which Scotland provided a microcosmic example of wider changes. It attempts to show the ways in which panoramic policy outlines were shaped by Scottish influences, the ways in which the aims of legislation were moulded, or surpassed, or thwarted, by Scottish factors, and the diversity which so often underlay both the broad pattern of U.K. policy and the service within Scotland itself.

Some explanation of the framework within which the 'Scottishness' of the service is seen, however, is necessary. The development of Scottish mental health policy cannot be dealt with in isolation from wider historical developments, and even an administrative or policy study must - if it is not to be history in a vacuum - take account of the wider debate regarding the history of psychiatry or mental health policy generally. It has, as Scull remarks, become a very 'creative and controversial' field.[4] The traditional approach (generally seen as exemplified by Kathleen Jones),[5] which sees development in terms of a gradual if not entirely uninterrupted progression towards the modern era, and which assumes the essential benevolence (or at least the neutrality) of psychiatry, has been subject to much criticism from those who believe it is too 'urbane',[6] too naive or simply wrong.

Much of the inspiration for this re-appraisal came from Szasz

who, in a series of onslaughts, denied the existence of mental illness and contended that psychiatry was partisan and oppressive, bent on the control of dissent or deviance.[7] But Szasz, a psychiatrist from what is generally regarded as the far right, dealing with the contemporary, has perhaps posed a less serious challenge to traditional concepts than historians; historians like Foucault, who contends that mental illness is a creation of civilisation,[8] like Scull,[9] Treacher and Baruch[10] and Ewins,[11] whose analyses are dominated by a conviction that the history of mental health is primarily the history of psychiatrists' struggle for hegemony, and Penfold and Walker[12] and Showalter,[13] who stress the extent to which psychiatry enshrined and reinforced the concept of female vulnerability and conventional gender roles.

These writers cannot all be lumped into the same 'anti-psychiatric' camp; there are many differences between them and there is, for example, a marked contrast between Szasz's polemics and Scull's meticulously researched historical analysis. Nevertheless, they share a rejection of the more traditional approach and their collective influence has been such that what was a challenge to convention has itself almost become the new orthodoxy; the 'Whiggish' or 'progressive' approach is, as Scull notes, now in disfavour.[14] However, the 'new' approach has in turn been criticised by those who, like McGovern, argue that social control interpretations have become 'trite' through excessive usage.[15] There are in fact many problems with using the model as a conceptual framework. The approach of the most extreme exponent of anti-psychiatry - Szasz - is indeed 'dogmatic and oversimplified'.[16] The unjustified application of social control theories primarily to mental health, the almost

unhealthy preoccupation with the power of the psychiatrist-cum-oppressor and the helplessness of the patient-victim, the glamorisation of misery as an expression of human freedom, the characterisation of psychiatrists as an amorphous mass dedicated to the subjugation of the human race and hyperbolic comparisons between psychiatry and slavery, totalitarianism and (at least by implication) Nazi war crimes,[17] all these undermine Szasz's case.

However, this thesis does not deny that the containment or suppression of deviant or anti-social behaviour was not infrequently one of the elements of policy. Psychiatry as an agent of social control was apparent in a number of areas subsequently described, and particularly in the concepts of moral defectiveness and psychopathy, in the pressure for sterilisation of the mentally disordered and in the 'disempowerment' that certification entailed. Psychiatry as an enforcer of dominant values can also be detected in the theory that the stresses of 'femaleness' were a contributory cause of mental disorder. Above all, perhaps, it is undeniable that psychiatry did lay claims to progressively larger areas of personal conduct. This 'widening of the medical and public view as to what constitutes insanity' was recognised as early as 1906,[18] and in the years which followed the mental health service expanded to encompass larger numbers of the mentally handicapped, the neurotic and the psychopathic.

But an acknowledgement that social control or the 'psychiatricisation' of abnormality was in some cases one of the functions of mental health policy is not the same as accepting that it was its primary motivation or inevitable result. The social control perspective has played a valuable role as a catalyst for the re-examination of traditional and even complacent attitudes. But if it

is important to question the linear view of the history of the mental health service it is equally crucial to question the more fashionable and cynical perspective which sees change solely in terms of a tightening of psychiatry's stranglehold. A too-ready and almost knee-jerk dismissal of legislative, medical, administrative or organisational reform as a mere side-show to the real drama of the inexorable process of psychiatric domination, and the characterisation of apparent change as 'playing musical chairs to a new tune',[19] is limiting. It is surely dangerous virtually to rule out even the possibility of more profound change.

While this thesis tries to escape the constraints of opposing syndromes, it also avoids seeing mental health policy in terms of provision for the mentally ill. Some of the more 'controversial' questions relating to mental handicap - particularly intelligence tests and the eugenics movement - have attracted considerable attention. Some work has been done on special education. There has also been some sociological investigation of the contemporary experiences of the handicapped. But the historical development of the service for the mentally handicapped remains a relatively fallow field when compared with the service for the mentally ill, and histories of 'mental health policy' sometimes contain scant reference to the handicapped.

This may be because, in crude terms, mental handicap seems less exciting than mental illness. Intellectual impairment is concrete: while the perception of what constitutes higher-grade defect is undoubtedly affected by political, economic, social or cultural norms, it is difficult to deny the existence of severe mental handicap, or to attribute it to civilisation or capitalism. The history of mental

handicap may therefore offer less scope for theoretical pyrotechnics. Mental handicap is also somewhat removed from the mental health mainstream. Some of the major preoccupations of modern historians of the service - including the morality of radical physical treatments like leucotomy or E.C.T., the role of psychotherapy and the psychiatric oppression of women - have little or no relevance to the handicapped. Those which are pertinent - such as the ethics of compulsory hospitalisation - do not seem to be such a bone of contention, perhaps because the fate of those who in many cases never had been and never would be 'normal' somehow seems less important than the treatment of those whose condition was often transitory. It is, then, almost as if the perception of the condition of handicap as essentially static, and of the handicapped as almost bovine, has been mirrored in the historical debate, or the lack of it. The second-class position that the mentally handicapped occupied within the mental health service has often been reflected in the literature which excludes or ignores them.

However, if mental health policy rather than policy for the mentally ill is to be discussed, then the service for the mentally handicapped must be included. The mental deficiency service was different from the lunacy service; in particular, it was a younger service the (real or avowed) aim of which was not cure but training, support and, certainly, control. But it was neither unchanging nor uninteresting. This thesis attempts to redress some of the imbalance by including the development of services for the handicapped - which embrace special education, training facilities and day centres, as well as institutionally based services and community care - within the discussion of mental health policy.

However, even the use of terms like 'mentally handicapped' and

'mentally disordered' is controversial. The significance of terminology was a constant theme in the period 1908-60 as well as of the contemporary debate. The language used to describe those labelled as mentally disordered is, for adherents to the social control model, an essential part of the process of domination; it is 'the rhetoric of rejection'.[20] To others, terminological change is evidence of the increasingly positive attitude towards mental disorder. There is therefore a consensus that 'what's in a name?' is not applicable in the mental health context and that descriptive terms reflect and encourage positive or negative attitudes. The perjorative connotations - or the 'emotional charge of contempt, or horror, or derision, or at least condescension'[21] - which terms like 'lunatic', 'defective', 'idiot', 'imbecile', or 'feeble-minded' carry, as well as the acceptance of the disease model inherent in their use, means that some writers have avoided them; Ramon, for example, substitutes 'mental distress' for mental illness.[22] But this term and any other which can be thought of is hardly less judgemental or subjective than the older terms or the more modern ones. It also seems ahistorical not to use the terms which were the common currency of the time. In this thesis, therefore, the contemporary terms for the apparatus and clients of the mental health service are generally used.

This thesis therefore attempts to provide a catholic perspective on the development of mental health policy and the service for the mentally disordered in Scotland in the period 1908-60. An eclectic approach has previously drawn accusations of 'empiricist anti-intellectualism'[23] but empiricism is perhaps a more useful approach to a subject as complex as mental health policy than is a rigid adherence to either of the two major theoretical models. A desire to help and a

desire to control are far from mutually exclusive and mental health policy in Scotland was often, in Ramon's phrase, 'a combination of control and care, where the balance is modified in accordance to the social context and professional contributions'.[24] Sometimes neither care nor control were the paramount considerations and other factors - including 'diplomacy', or the need to satisfy or to avoid alienating particular groups, and economic exigency or expediency - played a significant role in the formulation and implementation of Scottish policy. The social control and march of progress camps frequently seem to answer only one half of the question. The former's pre-occupation with motives - the 'why?' - sometimes provides little sense of the actual impact of policy, while the latter's concentration on results - the 'how?' - can result in a bland 'travelogue'. This thesis tries to provide a flexible response to the question of why and how the Scottish service developed during the period 1908-60.

PART I

Reform Begun and Frustrated, 1908-18

Chapter 1 The End of the Lunacy Service

(i) The service for the mentally disordered on the eve of reform

(ii) The pressure for reform

(iii) The Mental Deficiency and Lunacy (Scotland) Act 1913

(i) The service for the mentally disordered on the eve of reform

The service for the mentally disordered before 1913 was essentially a lunacy service; the only class of the wider group later termed 'mental defectives' who could be dealt with under the Lunacy Acts were 'idiots'. Dissatisfaction with the narrowness of the service crystallised during the period 1908-13, when the Report of the Royal Commission on the Feeble-Minded (1908) and the Report of the Royal Commission on the Poor Laws (1909) reflected and further stimulated the growing belief that new powers for the protection and control of mental defectives as a whole were urgently needed. The pressure for reform culminated in the Mental Deficiency and Lunacy (Scotland) Act 1913, which created the mental deficiency service. This chapter opens with a description of provision for the mentally disordered on the eve of reform. It examines the mounting impetus for the establishment of a more comprehensive service, and concludes with an analysis of the seminal 1913 Act.

The vast majority of lunatics who were under care in 1908 were compulsory patients. The procedure for a patient's compulsory admission and detention involved tripartite lay, medical and legal authority. The process was set in motion by the petitioner, who was usually the patient's nearest relative in the case of private patients, and in pauper cases was invariably the Inspector of the Poor.[1] This lay authority drew up a petition for commital and a statement of particulars regarding the alleged lunatic. The next step required two medical practitioners to certify, independently, that the person in question fell into one of the four categories for certification; that he or she was a 'lunatic', an 'insane person', a 'person of unsound mind' or an 'idiot'. The petition, statement and

certificates were then submitted to the legal authority, the Sheriff,[2] for a warrant for the lunatic's removal and an order for his admission and detention in an asylum, or other institution, or private dwelling. If the patient was not discharged in the meantime, the order remained in force until the 1 January first occurring after the expiry of three years from the date it was granted, unless the asylum superintendent certified, then and in every succeeding year, that continued detention was necessary.

While this was the normal procedure for compulsory admission, there were various other forms of certification. The 'Certificate of Emergency' was, as its name implies, intended for use in urgent cases; under it, a single certificate was granted by the Medical Superintendent, or Assistant Medical Officer, of the asylum to which the patient was admitted, and it authorised his detention pending the obtaining of a Sheriff's order. Special provision was also made for dangerous lunatics; under section 15 of the 1862 Lunacy Act, a lunatic found in a state threatening danger to others, or in a state of offensiveness to public decency, could be detained forthwith, in a place of safe custody, by the Sheriff. After further formal proceedings, during which a supporting medical certificate had to be produced, the Sheriff could commit the lunatic to an ordinary asylum. Two other forms of certification applied only to patients admitted to private dwellings. Section 13 of the 1866 Lunacy Act empowered the Sheriff to grant an order for the detention of a pauper lunatic under guardianship on the authority of a single certificate, while private patients whose insanity was not confirmed could, under the terms of the Six Months Certificate, be placed under private care for up to six months.

The nineteenth-century Lunacy Acts which laid down the

procedures for detention recognised that they had the potential to be abused, and some safeguards were built into them.[3] But the danger, for the most part, lay not in the manipulation of the process for devious purposes, but in the very fabric of the system itself, particularly in respect of the definition of lunacy and the role of the experts invoked. A 'lunatic' was simply a person certified by two doctors to be a lunatic, person of unsound mind, insane person or idiot. No precise definition of what these terms meant was given; the sort of behaviour or mental condition which was to be regarded a lunacy, idiocy, insanity or mental unsoundness was left to the judgement of the certifying doctors. The lack of any criteria meant that doctors had enormous scope for discretion, and what might be regarded as certifiable behaviour by one doctor might not be so regarded by another.

The lack of any objective standards was compounded by the fact that many certifying doctors were ill-equipped to make evaluations about lunacy. Psychiatry and psychology played little part in the undergraduate medical curriculum, and there was no requirement for the certifying doctor to have any additional qualification, or any particular experience, in the field of mental disorder.[4] Many doctors thus had little training in, or acquaintance with, mental disorder. Nor was there any requirement for them to be familiar with the patient or his past history, and in many cases, patients were certified by doctors who had never seen them before. Accurate diagnosis was, in these circumstances, problematical.

The legal participant in the detention process, however, never saw the patient at all. The Sheriff's main role was to check that the paperwork was in order, although it was understood that he also judged

whether the facts set down were reasonably sufficient to show that the person for whom the order was sought was a lunatic. He was not equipped to make any medical judgement, however, nor was it intended that he should. The Sheriff was empowered to refuse to grant an order, and there were occasions when that power was exercised. But the granting of an order was essentially an administrative act, and the Sheriff often functioned as a 'rubber stamp' to the medical opinion stated in the certificates. In contrast to England, medical opinion was the final arbiter of lunacy in Scotland.[5]

Not every patient was subject to these procedures, however. Voluntary admission at the patient's own request had been sanctioned since 1862,[6] and subsequently the procedure had been simplified. A medical superintendent could admit into his asylum as a voluntary patient any person who was desirous of submitting himself to treatment but whose condition did not warrant certification; the only condition attached was that the written assent of a Commissioner of the General Board (the central lunacy department) had to be obtained before admission. Scottish lunacy legislation was, in this respect, in advance of English legislation, which specifically restricted voluntary admission to private patients and to certain types of institutions.[7] No such limitations applied in Scotland, where the provision for voluntary treatment contradicts the common view of Scottish policy as a somewhat backward cousin of its neighbour.

In practice, however, voluntary treatment was far from universally available. Patients who were unable to make the positive application that voluntary admission required were ineligible for it. Those who were willing to make an application but who were certifiable were also, it appeared, excluded from voluntary treatment, though the

Table 1:1 Voluntary Patients in Asylums, 1908-14

No. resident on 1 January each year	No. admitted in 12 months preceding 1 January each year	
	87	Average no. admitted in 10 years 1898-1907
1908	109	120
1909	109	106
1910	99	91
1911	127	108
1912	118	119
1913	130	115
1914	148	112

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland

terminology of the provision did not put the question beyond all possible doubt.[8] Further, the delay entailed in the necessity to obtain the General Board's sanction before admission prevented voluntary treatment at the earliest possible opportunity and it had, in at least one case, resulted in tragic consequences.[9]

The most serious limitation on voluntary admission, however, was that whilst it was theoretically available irrespective of the patient's means, it was, in reality, barred to paupers and thus to the vast majority of lunatics. The Pauper Lunacy Grant which was paid from central government was for certified lunatics only: the cost of any voluntary paupers would thus have devolved upon the parish council, and these local authorities were unwilling and, in most cases, unable to countenance such a heavy financial burden.[10] So strong was the economic disincentive that pauper patients were effectively excluded from voluntary treatment, which was confined to a handful of private patients.[11]*

Thus, as a consequence of their legal status, as well as their mental condition, lunatics were in an almost uniquely vulnerable position, and the necessity to protect their welfare had long been recognised. The responsibility for doing so had, since 1857, rested with the General Board of Commissioners in Lunacy for Scotland, an independent statutory body charged with the quasi-judicial function of safeguarding the interests of individual patients, and with the concomitant administrative function of the supervision and regulation of the institutional service. The Board's composition reflected its duality of function. It comprised a Chairman and four other Commissioners. Two of them were doctors, and these 'Medical Commissioners' undertook one of the most important of the Board's

11.

* 11 Table 1:1

functions, the visitation and inspection of all lunatics in institutions, and the Board's day-to-day work; they were assisted by medical Deputy Commissioners, who were not Board members.[12] The other two Commissioners were legally qualified, and these 'Legal Commissioners' dealt with all legal questions.[13] All members of the Board met regularly.[14]

Various local authorities also had duties in respect of the mentally disordered. Relief for those who, by reason of bodily or mental infirmity, were prevented from working, and who had no other means of subsistence, was provided under the Poor Law. Although it was organised on a two-tier system, with the central Local Government Board for Scotland acting in a supervisory capacity,[15] the responsibility for the administration of the Poor Laws rested with over 800 elected parish councils. Much of the day-to-day work was performed by Inspectors of Poor, parochial officials who were the grass-roots representatives of the machinery of the Poor Law. Each parish was required to appoint at least one, and some large parishes had more than one. Some were part-time, and others were full-time, but in almost every case they had considerable power, and the decision whether or not to grant relief was usually left in their hands. Relief could be 'outdoor' - domiciliary - or 'indoor' - in poorhouses erected by parish councils for the purpose - but, although the Scots system had traditionally been one of outdoor relief there was, by the twentieth century, a substantial network of poorhouses. Finally, the last legal point to make is that the parish was empowered to recover, where possible, the cost of any relief given either, subsequently, from the person relieved or from his or her relatives, and the scope of this family liability was far wider under Scots than English law.[16]

Table 1:2 Registered Lunatics, 1908-14*

Date	Pauper	Private	Total
1 Jan. 1908	14,980	2,434	17,414
1 Jan. 1909	15,203	2,478	17,681
1 Jan. 1910	15,386	2,406	17,792
1 Jan. 1911	15,640	2,419	18,059
1 Jan. 1912	15,964	2,455	18,419
1 Jan. 1913	16,115	2,437	18,552
1 Jan. 1914	16,218	2,464	18,682

* Excluding the inmates of Training Schools for Imbecile Children, and of the Criminal Lunatic Department.

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland

As Table 1:2 shows, at this time the majority of lunatics in Scotland were pauper lunatics, dealt with by the parish council as part of their wider duty to provide for those who were both poor and disabled. In any case in which a poor person chargeable in any parish became 'insane or fatuous', the Inspector of Poor was required to make arrangements for his certification. The parish council was then required to provide for the patient's conveyance and admittance to an asylum or other establishment legally authorised to receive pauper lunatics, though it could, with the consent of the General Board, dispense with removal and provide for the patient in other ways, such as leaving him under the care of his natural guardian, or placing him with an unrelated guardian.[17] But however the patient was dealt with, the Inspector of Poor was bound to notify his presence, and the steps that had been taken in his case, to the General Board, and the parish council was bound to maintain him, out of money derived from state funds and locally levied rates. Pauper lunatics, wherever placed, were regularly visited by the Inspector of Poor, and the discharge of a pauper from care was, in most cases, by minute of the parish council; the relatives of pauper lunatics, unlike those of private lunatics, had no powers of discharge, and the asylum superintendent could only overrule a parish council's application for discharge if he believed the lunatic was dangerous.[18] Almost every aspect of the pauper lunatic's 'career' was under the control of the parish council.

However, the lunacy powers of parish councils were not always clear. There was some doubt as to its power to take action in a case reported to it which did not fall within the categories of danger or offensiveness referred to in section 15 of the Lunacy (Scotland) Act 1862. There was little difficulty in dealing with a person who became

certifiably insane while receiving poor relief, particularly if relatives had requested the Inspector of Poor to take action. But the statutes were not very helpful in the case of a person, brought to the notice of the Inspector of Poor, who was not actually in receipt of poor relief at the time, and who was thus not a pauper lunatic under the terms of the Acts.[19] There was also a question mark over the local authority's power compulsorily to remove a certified lunatic whose relatives would not consent to it, and again, the problem was particularly difficult if the person in question, though certified at the instance of the Inspector of Poor, had not received any parochial allowance before the time of certification.

The situation in respect of mental defectives was even more confused. The 1845 Poor Law Act required parish councils to deal with 'fatuous' paupers. Fatuousness, however, was not a certifiable condition. Nor was 'imbecility', although it appeared that a substantial minority of certified patients were indeed 'congenital imbeciles' who were not idiots.[20] While it is far from clear, it appears that some less severely defective patients were certified as 'lunatics' or 'persons of unsound mind'. Again, however, it was not certain whether parish councils were obliged, or even entitled, to deal with this group.

There was, then, a 'twilight zone' in which the powers of parish councils were rather obscure. However, it appeared that if the lunatic was not in receipt of relief, and if his relatives were unwilling to countenance his removal, the council's power to act might be limited to the institution of proceedings under section 15; if the lunatic did not come under its provisions, or was a mental defective who was not an idiot, it seemed doubtful whether the local authority

could act at all. It is very difficult to assess the effect of this legislative vagueness upon lunacy administration 'on the ground', or to estimate the number of people who might have been affected by it. But the opportunity for inactivity that such confusion afforded was particularly significant in view of the pressure of those with whom the parish council was required to deal.

For the economic burden of pauper lunacy was, in the early years of the century, a growing one. The contribution from state funds towards the annual cost of maintaining pauper lunatics had, since 1900, remained steady at between £115,000 and £116,000.[21] Parish councils' expenditure on pauper lunatics, however, had risen and, by 1909, stood at over £400,000 per annum, most of it for asylum expenses; the amount recouped from relatives had fallen slightly and in 1909 was, at just over £20,000, an insignificant proportion of total expenditure.[22] The increase in cost was partly due to the growth in the number of pauper lunatics since 1900, and partly to the rising cost of keeping lunatics in asylums.[23] The result was that central government's share of expenditure was falling quite substantially. In 1900, the state contribution had amounted to 3s 9d per patient per week. By 1909, it was only 3s 1½d per week, at a time when the average cost of keeping a patient in an asylum was 1s 6d per day and was, in some instances, considerably higher.[24] And, by 1911, the weekly contribution per patient from the state had actually dipped to below 3s.[25]

Moreover, financial difficulties were, in many areas, exacerbated by geographic and demographic factors. For small, thinly-populated, poor and remote parishes, the cost of maintaining pauper lunatics was only one aspect of the problem. Certification and the

obtaining of a judicial order entailed expense and was difficult, though it was somewhat eased in 1913 when Parliament, under the terms of the Highlands and Islands (Medical Service) Grant Act, provided a grant to attract doctors to the area. Access to the Sheriff was also difficult, and special provision for remote areas enabled a Justice of the Peace, on the evidence of a 'person of respectability', to grant a warrant for the lunatic's detention and transportation to the nearest Sheriff. But transportation, too, was fraught with problems. There were no asylums in the Hebrides, Orkneys or Shetlands, and, even after the certificates and order had been obtained, the lunatic, and attendants, had to be conveyed long distances across land and water to mainland asylums, again at considerable expense.[26]

In these circumstances, some rural parishes found it increasingly difficult to fulfil their lunacy obligations. The cheaper alternative to institutional care - placing the pauper in a private dwelling[27] - was also fraught with similar problems in respect of certification and transportation. As a result, the service for the mentally disordered was divided on regional as well as class lines. While it was comparatively easy for a pauper lunatic in an urban area to receive treatment - perhaps even, in a few cases, at an early stage and without judicial process[28] - many barriers stood in the way of the treatment of pauper lunatics from isolated parishes.

The main institutional provision for pauper lunatics was in district asylums, and a second local authority - the district lunacy board - was responsible for their provision, maintenance and management. Under the terms of the 1857 Lunacy Act and the 1882 Lunacy District Act, Scotland was divided into lunacy districts for district asylum purposes; there were, following numerous alterations, twenty-

seven such districts in the early years of the century.[29] In large towns, the area of the district board was the parish, and the parish council and the district board were the same body - that is, the parish council acted as the district board for district asylum purposes. Otherwise, however, lunacy districts consisted of whole counties, or groups of counties, and the district board consisted of representatives from county councils and town councils in the district, the numbers on each district board being fixed by the General Board.

District boards were required to provide suitable and sufficient institutional accommodation for pauper lunatics in the district, by either erecting or acquiring district asylums, or through contracts made with the managers of other - Royal - asylums.[30] This aspect of their work was all but completed by 1908, but they continued to have wide powers over the institutions which they had provided. District boards appointed - and could dismiss - the officers and servants of district asylums and determined their wages and conditions of service. They also determined the rates of board for asylum patients. They did not have complete autonomy, since some of their powers were subject to the approval of the General Board. But they were responsible for the general well-ordering and discipline of the asylum.

The relationship between parish councils and district boards was, in the early years of the century, showing signs of strain. While there were few problems where the two local authorities were the same body, in other areas the fact that one local authority was responsible for maintaining pauper lunatics, and quite another responsible for the management of the institutions in which the majority of them were accommodated, meant that there was little

co-ordination between these twin aspects of provision. Parish councils had no control over the administration of district asylums, and on the basis that he who pays the piper should have at least some part in calling the tune, they sometimes resented it, particularly as the costs of maintenance rose. The situation whereby separate bodies had distinct yet intimately related responsibilities towards those who were certified under the Lunacy Acts but who remained firmly within the framework of the Poor Law was not conducive to the development of an integrated system of local lunacy administration. It was, however, symptomatic of the wider problem which was the almost inevitable result of the growth of specialist authorities, like district boards, alongside the long-established parochial system.

Moreover, another local authority also had powers in respect of the mentally disordered. The Education of Defective Children (Scotland) Act 1906 empowered school boards to make special provision for the education of 5-16 year old mental defectives - those who were not 'imbeciles' and not merely 'dull or backward' - who were incapable of deriving proper benefit from instruction in an ordinary school. By 1908, some provision had been made in the cities,[31] but the discretionary nature of the school boards' responsibilities meant that, in general, little had been done. The provision in special schools and classes was woefully inadequate, and most mentally defective children either received no education or attended ordinary classes which did not cater for their special needs.

The Act was, nevertheless, important, since to a large extent it laid the framework and set the pattern for future developments. It established the school-leaving age for defectives, at sixteen, higher than that for the ordinary school-leaver. It distinguished between

those who were actually defective, and those who were merely, in modern terminology, educationally subnormal. Most importantly it differentiated between defectives who were, by implication, incapable of deriving benefit from even special education, and defectives who could profit from education adapted to their needs. Its division of mentally defective juveniles into the educable and ineducable would remain a feature of Scottish special education for over half a century.

The variety of institutional provision was yet another aspect of the prevailing legal and administrative complexity. Royal or Chartered asylums, which were voluntary hospitals, were the oldest asylums in Scotland. The first, the Sunnyside Royal Asylum, Montrose, was established in 1781, and was followed by Aberdeen (1800), Edinburgh (1813), Glasgow (1814), Dundee (1820), the Murray Royal Asylum, Perth (1826), and, finally, the Crichton Royal Institution, Dumfries (1839).[32] The last two were erected out of funds provided by the benefactors whose names they bore; those in Aberdeen, Edinburgh, Glasgow, Dundee and Montrose were erected from funds derived from subscriptions and donations raised locally, including, in some cases, contributions from parochial sources.[33] Royal asylums had no equivalent in England, where the roughly equivalent institutions (Registered Hospitals) were smaller and were, most importantly, not chartered. The granting of a Royal Charter was not a mere formality. The asylums were, in the twentieth century, still bound by the terms of their charters, which covered such matters as the constitution of the asylums' boards of management. Chartering also designated the asylums as one of a special group of institutions which were distinguished not only by the near total absence of legislation associated with their establishment or function, but by the extent to

Table 1:3 Private and Pauper Patients in Institutions, 1908-14

Nos. on 1 Jan.	Royal Asylums		District Asylums		Private Asylums		Parochial Asylums		Lunatic Wards	
	Pvt.	Pauper	Pvt.	Pauper	Pvt.	Pauper	Pvt.	Pauper	Pvt.	Pauper
1908	1,908	1,703	302	9,186	97	-	-	568	-	743
1909	1,940	1,701	329	9,380	90	-	-	560	-	736
1910	1,901	1,683	297	9,823	88	-	-	213	-	824
1911	1,902	1,726	310	10,001	90	-	1*	201	-	834
1912	1,934	1,779	320	10,217	85	-	-	206	-	861
1913	1,931	1,790	312	10,347	82	-	-	228	-	841
1914	1,964	1,816	319	10,487	71	-	-	226	-	856

* For reasons which were not clear , a private patient was resident in a parochial asylum at this time.

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland

which they continued thereafter to enjoy a large measure of independence. While patients in Royal asylums were, like those in other institutions, visited and inspected by the Commissioners of the General Board, the Board had no power to limit the numbers in the asylums, or to make rules and regulations for their good order and management.

The particular object of Royal asylums' charity were poorer private patients, many of whom were saved from the ignominy of pauper lunacy by their reception at low rates of board. All Royal asylums had, at one time, also admitted paupers, but their accumulation had threatened to adversely affect the institutions' special charitable function, and also, perhaps, their status. Some Royal asylums, then, had ceased to receive paupers and, by 1908, only those in Aberdeen, Montrose, Edinburgh and Dumfries continued to do so, under contract with the parochial authorities which paid the paupers' costs. Private patients, however, still formed the majority of the population of Royal asylums,[34]* and the institutions were by far the most important form of provision for them; in 1908, three-quarters of all registered private lunatics were resident in Royal asylums.[35] It was the status of the majority of their patients, together with their position as voluntary hospitals not associated with local authorities, which, in the twentieth century, enabled Royal asylums to retain, to a large extent, the prestige they had previously enjoyed. They were still widely regarded as the elite of Scottish lunacy provision, with the Crichton Royal Institution as the 'creme de la creme'.

The local authority district asylums, like Royal asylums, also received both private and pauper lunatics. But the overwhelming majority of their patients were paupers[36] - indeed, in 1909, district

* 34 Table 1:3
* 35 Tables 1:2 and 1:3
* 36 Table 1:3

asylums contained three-quarters of all pauper lunatics resident in institutions. They had been established, under the terms of the Lunacy (Scotland) Act 1857, specifically to cater for paupers. Some of the buildings had been taken over by district lunacy boards - Elgin District Asylum, for example, had, prior to 1857, been a charitable hospital and Kirklands District Asylum was previously a private asylum. Others, however, were purpose-built, and their erection had been protracted; among the last to be opened were Kingseat District Asylum, Aberdeen, and Bangour District Asylum, Edinburgh, in 1904, while the last to be built, in Renfrew, did not open until 1909.[37] District asylums were, nevertheless, in terms of patient numbers, the most important form of institutional provision.[38] When substantially complete in 1908 they accommodated more than half of all known lunatics, and had a population which approached 10,000.[39*]

Private asylums, run by individuals for profit had, in the nineteenth century, formed a significant part of the total institutional provision for pauper lunatics. By the early years of the twentieth century, however, the accommodation which was provided in district asylums had supplanted them; they had long since ceased to receive paupers, and catered only for private, wealthy patients. Their relative importance had declined dramatically; by 1908, the remaining three private asylums - Balgreen, New Saughton Hall and Westermains - together provided accommodation for less than one hundred patients.[40] These asylums were licensed by the General Board, which also made rules and regulations for their good order and management.

However, despite the amount of new accommodation provided in district asylums, in 1908 around one-tenth of all pauper lunatics in

*39 Table 1:3

*40 Table 1:3

institutions - over one thousand patients - were accommodated in sections of poorhouses set aside for them.[41]* There were two forms of this provision. There were 'lunatic wards with a restricted licence' in a dozen poorhouses. They were repositories for chronic lunatics; under the terms of their licences they received only non-dangerous lunatics who did not require curative treatment. Under special provision, lunatics were admitted to lunatic wards without a Sheriff's order,[42] and a resident medical officer was not generally required. Lunatic wards were managed by the poorhouse committee of the parish council, with the governor of the poorhouse in the position of Superintendent, but the accommodation in them was entirely separate from that occupied by the ordinary pauper inmates.

There were also, in 1908, 'lunatic wards with an unrestricted licence' in three poorhouses: they were, for purposes of clarity, normally called 'parochial asylums'. They received paupers suffering from all forms of insanity, including those who were curable or dangerous, on the authority of a Sheriff's order. Parochial asylums had been established, in the mid-nineteenth century, as a temporary expedient for pauper patients until district asylums had been built, but the slow pace at which new accommodation had been provided meant that this stop-gap measure became a semi-permanent part of provision.[43] But parochial asylums were still the dinosaurs of Scottish lunacy provision. Some - like Woodilee Asylum in Glasgow - had already been redesignated as district asylums, and following the similar step taken in respect of Paisley Parochial Asylum, Riccartsbar, there was, by 1912, only one, in Greenock, which accommodated just over two hundred patients. The General Board moreover had no power to authorise the establishment of any more institutions of this type.

*41 Table 1:3

These lunatic wards must not be confused with the observation wards which some of the larger urban authorities had opened in Poor Law hospitals to accommodate paupers in the early stages of mental illness. These wards provided the sole means by which paupers could receive institutional treatment without certification[44] - indeed, certified patients were specifically excluded from them. The first, consisting of six beds for each sex, had been opened in Barnhill Poor-house, Glasgow, in 1890. It proved so successful that when the Eastern District Hospital opened in 1904 two wards, of twenty-five beds each, were set aside as observation wards. The example set by Glasgow Parish Council was also followed by those of Govan, Paisley and Dundee, and regulations which, inter alia, limited the normal period of stay to six weeks, had been drawn up by the Local Government Board and the General Board.[45]

Observation wards did not form a very significant part of total institutional provision,[46] but their importance was out of all proportion to their size. They provided a bridgehead between the asylum and the general hospital, and a model for the future development of psychiatric out-patient departments. They showed that, on a small scale at least, it was possible to treat pauper mental patients on the same basis as the physically sick, and demonstrated that pauper patients were willing to receive treatment without certification. But if they provided a breach in the general principle that compulsion was an essential corollary of the treatment of pauper patients, it was a very tiny breach.

The only specialist residential provision for mentally defective children available in the early years of the century was that provided by the National Institute for Imbecile Children,

Table 1:4 Lunatics in Private Dwellings, 1908-14

Date	Pauper	Private*	Total
1 Jan. 1908	2,780	127	2,907
1 Jan. 1909	2,826	119	2,945
1 Jan. 1910	2,843	120	2,963
1 Jan. 1911	2,878	116	2,994
1 Jan. 1912	2,901	116	3,017
1 Jan. 1913	2,909	112	3,021
1 Jan. 1914	2,833	110	2,943

* Private lunatics in private dwellings with the sanction of the General Board.

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland

Larbert, and the smaller Baldovan Asylum for Imbecile Children, situated near Dundee.[47] Both were charitable institutions, erected by voluntary subscription. They were licensed and inspected by the General Board, although the inmates of the institutions were not included on the Board's General Register of Lunatics. The institutions together provided accommodation for over four hundred children in 1908. They received, from all parts of Scotland, both private and pauper patients and a significant minority of inmates were accommodated gratuitously. The children had various forms and degrees of defect, and the institutions offered a combination of education and 'industrial training', with those who were capable of it learning scholastic subjects, and all being taught practical skills. The General Board was unstinting in its praise of the institutions' accomplishments,[48] and a growing number of parents and local authorities seemed to share their opinion; by 1913, the institutions' population had grown to almost six hundred, the majority paupers.[49]

The final type of institutional provision for the mentally disordered was the Criminal Lunatic Department of Perth Prison. It contained those who became insane whilst in prison, as well as those detained during His Majesty's Pleasure - 'King's Pleasure Lunatics' - who had either been acquitted of offences on account of insanity, or had been found to be insane in bar of trial. The inmates - whose numbers fluctuated between fifty and sixty in the years 1908-13 - were maintained at the expense of the State. In common with all other institutions for lunatics, however, the Department was regularly visited and inspected by the General Board's Commissioners.

But institutions did not accommodate all the lunatics in Scotland, and many lived in private dwellings (Table 1:4).

Their actual number was unknown since the State did not, in general, concern itself with those who lived with their natural guardians and who were not paupers; private lunatics resident with their families were brought under supervision only in special circumstances.[50] The law, however, did step in when a private lunatic resided with strangers, since it required a Sheriff's order or the General Board's sanction; the number of private patients in private dwellings with the Board's sanction was, however, very small, and never rose much above one hundred in the early years of the century.[51]* The number living with their natural guardians, or, indeed, living with unrelated guardians who had not complied with the statutory requirements can only be a matter of speculation, and private patients in private dwellings were to a large extent a 'submerged' section of the mentally disordered.

The vast majority of known lunatics in private dwellings, then, were paupers, since they came on the register of the General Board irrespective of whether they lived with relatives or strangers. In the early years of the century about one-sixth of all pauper lunatics lived in private dwellings.[52]* Of that number, around one-third - about a thousand patients - lived with related guardians. The majority, however, some eighteen hundred patients - lived with unrelated guardians, under the 'boarding out' system. The large-scale use of the policy was, at least in the context of the United Kingdom, uniquely Scottish.[53] Its roots lay in the Scottish Poor Law, with its greater emphasis on outdoor relief, and children who were orphaned, deserted or otherwise separated from their parents were, in the nineteenth and early twentieth centuries, frequently placed with guardians. The extension of the practice to the mentally disordered -

* 51 Table 1:4

* 52 Tables 1:2 and 1:4

adults as well as children - whose families were unable or unwilling to keep them probably developed as a response to the lack of asylum accommodation, but even after the erection of district asylums in the latter part of the nineteenth century it remained an essential part of Scottish lunacy provision.

Those who were boarded out under the system were placed in private dwellings by the parish council, which paid their guardians a modest remuneration for the patient's upkeep.[54] Boarders were not a homogeneous group. They were more or less evenly divided between those who were mentally ill and those who were congenital 'imbeciles'.[55] Most had previously been in an asylum, and had been removed to a private dwelling when they could no longer benefit from asylum treatment. But a significant minority - most of them congenitally mentally disordered - had never been in an institution, but were placed in a private dwelling directly following certification. The boarding-out system was thus at one and the same time both a form of after-care and an alternative system of 'community care'.

The boarding-out system had been placed on firm legislative foundations by the nineteenth-century Lunacy Acts, which legalised the boarders' position and instituted regulations for their supervision and care. A licensing system was introduced for guardians who wished to keep more than one lunatic. They were required to make an application for a licence to the parish council, which forwarded it to the General Board; it does not appear that the Board personally inspected the premises before making its decision and instead it seems to have relied on the information it received from the parish council. If the application was successful, the Board issued a licence which enabled the guardian to receive a specified number of lunatics, up to

the statutory maximum of four. There were in fact over five hundred licensed houses in the first decade of the century, the majority of them licensed to receive only two patients. Over one thousand patients - about two-thirds of all those boarded out - were resident in them. The majority were female, presumably because it was felt that they were easier to manage.[56]

In the first decade of the century, boarding out appeared to be as popular as ever and despite the increase in institutional accommodation there were in 1908 more boarders in private dwellings than ever before.[57] There were both economic and social reasons for its apparent continued success. It was, firstly, relatively inexpensive compared to asylum care.[58] But it would be inaccurate to depict it as merely a cheap expedient. The General Board was convinced that, when properly carried out, it was the ideal form of care for chronic patients. Country life was, it felt, generally more healthful, and the removal of the lunatic from the stresses and temptations of urban life was advantageous to him. It provided the homely atmosphere which an asylum, however well-run, could not hope to emulate. The greater freedom that 'family care' offered removed the feeling of imprisonment that the institution sometimes induced, while the opportunity for work that it afforded provided a natural outlet for the patient's energies. The General Board was convinced that therefore it was the most suitable, natural and humane provision that could be made for the chronic patient.[59]

The Board, indeed, felt that much more use could, and should, be made of the system. It was convinced that parish councils were sometimes slow to take advantage of it, and were particularly reluctant to remove lunatics to a private dwelling from an asylum.[60]

Financial reasons may have been partly to blame; the cost of transporting the patient, and attendants, to a private dwelling, perhaps only to have to return him to the institution at a later date, could be prohibitive, particularly to a remote parish. Some physician-superintendents, too, were reluctant to see a good worker removed to a private dwelling. But in many other cases, the Board felt, the cause was the parish council's sheer 'inertia and lack of interest'.[61] Some parish councils certainly appeared to be less than enthusiastic about boarding out. There were enormous variations, even between neighbouring parishes, in the extent to which the system was used, and in some in which boarding out was little used - like Falkirk - remoteness was not a factor.[62]

There were, however, other problems too. In the early years of the century, a change in the climate of opinion can be detected. The General Board became increasingly concerned by the reluctance of some guardians to take 'unproductive' patients who, though suited to family care in every way, were not capable of heavy labour. The Board deplored this attitude, stressing that the object of the system was the patient's happiness rather than the guardian's advantage. It attributed it to the greater frequency with which patients were boarded out on larger farms, and felt that some Inspectors of Poor compounded the tendency by dangling the patient's capacity for work as a carrot to prospective guardians.[63] It suggested that guardians should be more carefully selected and urged that male patients should, whenever possible, be boarded on small crofts.[64] Nevertheless it does seem inevitable that some would always be attracted to guardianship by the prospect of gaining an extra farmhand whom they were actually paid to keep. The problem was, to a large extent, inherent in the system.

Moreover, despite the increasing tendency to board patients on larger farms, most guardians were not well off. As a consequence, the material surroundings in which many paupers in private dwellings were kept were of a relatively low standard. The General Board admitted that the conditions could not compare - as regards space, furnishing or decoration - with asylum accommodation. But it did not object to low material standards, as long as they were shared by the guardian and the boarder alike,[65] and still adhered to the general principle - laid down some fifty years earlier - that the conditions in which boarders were kept should approximate to that of the 'poor but respectable' portion of the general community.[66] Indeed, the Board seemed almost to welcome the spartan conditions in which many boarders lived; boarders were, above all, paupers, and the principle that there should be no incentive to reliance on relief applied to them. The poverty of many guardians on small farms (which did not offer the same opportunity for exploiting the patient as larger ones) was in fact seen as a positive advantage.

But the apparent increase in the number of guardians who were more interested in the patient's work-rate than in his welfare was only part of a wider problem. Although the General Board was careful to stress that there were many excellent guardians, it admitted that there were general difficulties. Passive neglect was more of a problem than active cruelty or ill-treatment, and, in particular, there was evidence that some patients were not treated as members of the family.[67] But it is very difficult to form an accurate picture of the scale of the problem or, indeed, to see what more could have been done about it, short of abolishing the system entirely. Boarders were already subject to extensive inspection,[68] and as a last resort the

General Board could revoke a guardian's licence. In rare instances, it actually did so,[69] although it more frequently used the threat of revocation to force unsatisfactory guardians to meet acceptable standards.[70] But in the end the success of the boarding-out system depended largely on the good will of guardians, since the scope that it afforded for economic, sexual or other forms of exploitation was virtually impossible to eradicate.

A distinct but related problem was the condition of those who were not boarded out, but who were resident with their nearest relative. It is impossible to form any impression of the condition, or even the numbers, of private patients living at home. But in the case of paupers, the General Board was convinced that, in general, their condition - their comfort, cleanliness and general well-being - was less satisfactory than that of paupers boarded with strangers. The main reason was that, in such cases, it was much more difficult to enforce adequate standards, particularly when the relationship was that of parent and child. No licence was, of course, required, and the General Board could not easily take the same 'strong action' to remove the patient that it could in the case of boarders; almost every year, the Board was 'confronted with difficulties of administration owing to [the] want of sufficient compulsory powers to effect the removal ... of patients where the guardianship of parents is bad and cannot be improved'.[71] There was, too, the added complication of the possible emotional damage that removal could cause, and the likelihood of adverse public reaction to statutory 'interference' in the family. Again, it was a problem that had no easy answer.

Finally, widespread use of boarding out meant that several thousand people were in more or less close contact with registered

lunatics. The effect of this proximity on guardians and their families, and particularly the element of danger which might be inherent in it, was the subject of some debate. Around the turn of the century, there had been a few violent incidents involving boarders,[72] but there was also a popular notion - from which medical opinion was not immune - that contact with the lunatic could be harmful; that mental illness was, in fact, almost contagious. The idea was, in the early part of the century, at least prevalent enough for the General Board to explicitly refute it. It rejected the idea that the mentally disordered were a threat - in any sense - to either the families they boarded with or to the community in general, and felt guardians shared this view.[73] It is more difficult, however, to judge whether boarding out actually played a positive role by dispelling some of the ignorance and prejudice attached to mental disorder. There is evidence that it did do so in the case of the family with which the lunatic was boarded,[74] but its effect on public opinion generally was more problematic. The most that can be said is that the public did not usually actively oppose the policy.

However, there was some public dissatisfaction with the presence of boarders in the community. In 1911, the General Board was sufficiently disturbed by reports of the 'evil results' of boarding mentally defective children from Glasgow on Iona to institute an inquiry into the matter.[75] In 1912, an anonymous correspondent from Gartmore, Perthshire, complained that boarders there were 'prejudicial to the interests of the villagers'[76] and, in the following year, the Inspector of Poor in Glasgow received a similar complaint from a Portmoak clergyman.[77] There is no evidence that such feelings were widespread. Nevertheless, the success of the boarding-out system

depended, to a large extent, on the good will - or at least the acquiescence - of the public, and even such isolated rumblings of discontent were worrying.

One cause of such public resentment was the element of 'culture shock' inherent in the contact between the inhabitants of remote rural areas and the products of deprived inner-city areas. The sheer number of boarders involved, however, also played a part. The complainant from Gartmore demanded a reduction in the number of boarders in the area, not their complete removal; indeed, only a month before receiving the complaint, the General Board had itself requested that the number sent to the parish should be restricted.[78] Similarly, the General Board had, just over a year before receiving the Portmoak complaint, advised Inspectors of Poor not to send any more boarders to the area.[79] It seemed that while boarders were tolerated in relatively small numbers, they became a source of irritation when present in larger numbers. A few parishes had reached saturation point during the early years of the century.

(ii) The pressure for reform

In the first decade of the century, therefore, the service for the mentally disordered was showing signs of strain. The General Board's powers to safeguard the interests of patients - particularly those in private dwellings and Royal asylums - seemed inadequate, and there was uncertainty about the powers of parish councils. The effects of the lack of co-ordination at local level, and the increasing expense of the service, were becoming more evident. Most importantly there was a general conviction that even though some mental defectives who were not idiots were being dealt with, the scope

of the service was too narrow to deal with all those who needed care, training or treatment. This became the particular focus of attention in the early part of the century. The reasons why, and the steps that were taken to remedy it, are discussed next.

The spread of the philosophy of eugenics [80] was an important factor in the pressure for reform. Eugenists were not a homogeneous group, and their ideas were not always coherent, but essentially they feared the physical and mental degeneration of the national stock and pressed for more or less radical measures to halt the supposed decline. The popularity of eugenism around the turn of the century was the result of many diverse factors. The experience of the Boer War and increasing industrial competition eroded the Victorian complacency which had assumed Britain's pre-eminence. The concept of Social Darwinism, which applied evolutionary theory to human society and postulated that civilised man was reversing the process of natural selection, added to the sense of decay. The increased interest in the new sciences of genetics and psychometrics seemed to provide a scientific basis for the mechanism of deterioration and a means of measuring it.

The increasing interest in eugenics in Scotland - which was reflected in the formation of a branch of the Eugenics Education Society in Glasgow in 1910-11[81] - was not, then, primarily related to the mentally disordered but was the product of a variety of political, economic, scientific and social factors. The mentally disordered, however, were a prime focus for eugenic activity. It was underpinned by a conviction that mental disorder, and particularly mental defect, was, like other mental traits, to a large extent of hereditary origin. The belief that hereditary unstable weakness - though in some

instances exacerbated by environmental influences - was the primary cause of mental disorder was not confined to eugenists: Scottish psychiatry generally held that nature was more important than nurture,[82] and a faith in the significance of genetic endowment did not inevitably lead to a predilection for eugenism. Nevertheless, it was, particularly if combined with other concepts about the mentally disordered, the fertile soil from which eugenism could grow.

This was particularly true when hereditarianism was coupled with a belief that mental disorder was the seedbed of much lawlessness and depravity. The concept that many of the mentally disordered were the possessors of 'prominent moral obliquity'[83] was reinforced by the fact that general paralysis of the insane - the tertiary stage of syphilis - was responsible for a large percentage of the admissions to, and deaths in, Scottish asylums.[84] Mental defectives were thought to be particularly prone to vice. There was, of course, the obvious point that the intellectual impairment which defectives suffered from left them vulnerable to those who would take advantage of their condition,[85] but to those who were not closely involved, it could seem that the fault lay with the victim rather than with the aggressor.

The supposed sexual proclivities of the mentally disordered also contributed to the growing belief that mental disorder was increasing. It was part of a more general perception that the less valuable elements of society were threatening to swamp the better endowed, thus leading to a decline in national efficiency. The process was attributed not only to the over-fecundity of the mentally disordered and other undesirables but to the efforts which had been made to improve their lot - Dr. Easterbrook, Superintendent of the Crichton Royal Institution, for example, felt that while in 'the

olden days' the weakest had gone to the wall, modern society, by protecting them, had interfered with 'a universal biological process', thus resulting in a large increase in their numbers.[86] Similarly, Lord Rosebery, at his address on the official opening of Bangour Asylum in 1905, waxed pessimistic upon the great increase of insanity.[87]

Some attempted to provide a corrective to this view. The General Board acknowledged that the number of the insane had increased in the half-century since its establishment and that, in particular, the number of lunatics on its register had increased by 197 per cent since 1858, while the population had increased by only 56 per cent during the same period. But this statistic, it stressed, had little bearing on the question of the nation's sanity, since the changes which had occurred in the meantime - particularly the growth of institutional accommodation - made such an increase inevitable.[88] George Robertson, Superintendent of Edinburgh Royal Asylum, also pointed to factors, apart from an actual increase in mental disorder, which could account for the rise, though he had little confidence in the public's ability to grasp them.[89] It did indeed appear that whatever efforts the Board, and others, made to try and put the figures into perspective, the degree of sophistication which was required to understand the trends which contributed to the apparent increase militated against acceptance of their arguments. The fact that they felt impelled to try and refute the idea of an increase in mental disorder - and the Board attempted this several times in the early years of the century - demonstrated the extent to which the concept had taken hold. Certainly, the prospect of an ever-increasing number of the mentally disordered, and particularly of pauper lunatics

needing to be maintained at public expense, stimulated increase in eugenist proposals.

The concepts that much mental disorder was hereditary, that it was often accompanied by a disposition to misbehaviour, and that it was a growing problem therefore meant that the mentally disordered were increasingly seen not merely as a burden to the community but as an active menace. There was a sense that society was under siege, and the enemy at the gates were the mentally disordered. This feeling was reflected in a belief that current methods of dealing with the mentally disordered were too permissive to be effective; Dr. John Macpherson, a Commissioner of the General Board, was convinced that eugenics - 'certain biological theories' - was at the root of the furore about boarders on Iona, for example.[90] In general, eugenism encouraged the belief that new measures to deal with the mentally disordered were urgently needed.

There were, however, even among eugenists differences of opinion about the steps that should be taken. Some felt that training did have a part to play in making defectives useful and in acting as a counterweight to the realisation of their hereditary disposition, but others were convinced that many defectives were 'so inherently vicious that no education and no environment could ... redeem them from the tyranny of their innate immorality'.[91] They felt that since the root of the problem lay in the defectives' tendency to transmit their condition to their offspring, the aim must to be curb reproduction. There was only limited support for surgical sterilisation in Scotland before World War One, although Dr. William Reid of Aberdeen Royal Asylum was one of those who introduced the possibility into the psychiatric arena by urging the sterilisation of 'moral perverts,

degenerates, epileptic and feeble-minded subjects'.[92] Even those who were not prepared to go so far, however, were convinced that the time had come for some sort of action.

Eugenics, then, was a powerful motivating force behind the pressure for reform. The concept that lunatics could be dangerous had long been held and was, indeed, enshrined in the Lunacy Acts. Eugenism, however, helped to foster the idea that mental defectives were dangerous too. Whether as delinquents, inebriates, unmarried mothers, or as the carriers of a morbid heredity, mental defectives were increasingly seen not merely as harmless, 'fatuous' unfortunates to be pitied or laughed at, but as threats to the safety and even the very existence of the nation. Eugenic pressure, together with the legal and administrative problems of existing provision described in the first section of this chapter, therefore played a significant part in the Government's decision to establish a Royal Commission on mental deficiency.

The remit of the Royal Commission on the Care and Control of the Feeble-Minded, which was appointed in September 1904, reflected the concept that the mentally defective were a menace. The Royal Commission was to consider the United Kingdom's existing provisions for idiots and for defectives not certifiable under the Lunacy Laws and, in view of 'the hardship and danger resulting to such persons and to the community from insufficient provision ... to report as to the amendments in the law or other measures which should be adopted'. However, these terms of reference were subsequently found to be too restricted to allow the comprehensive inquiry that the Commission wanted and in 1906 they were extended to include an investigation into lunacy administration in England and Wales.[93] Scotland (like Ireland) was not included in this wider remit and in making its recommendations

for Scotland, the Commission was still bound by the terms of the original Royal Warrant. However, it took a fairly elastic view and still produced a significant and wide-ranging review of the Scottish service.

In its 1908 report, the Royal Commission praised some aspects of the Scottish system, particularly observation wards and the 'economy and adaptability' of the boarding-out system. In general, however, it found the service for the mentally disordered in Scotland to be 'very far from satisfactory'.[94] Almost all of those involved in the service were criticised; parish councils did not always intervene when they should, and were especially reluctant to take action in respect of children. The problem was exacerbated by the lack of special schools and classes and residential institutions. Asylum authorities were also accused of inaction, and especially of showing a reluctance to part with useful patients.[95]

Nevertheless, although it was critical of the administration of the existing law, the Royal Commission did not believe that it was the outstanding problem. It was convinced that the current legislative framework, however diligently administered, was simply too narrow and was inadequate to deal with all those who required care and control. A large group of the mentally disordered could not be certified, and thus those mental defectives who were not 'idiots' were generally prevented from receiving the services which they required. The Commission's overriding objective was to bring these people within the scope of statutory provision so as to create a more comprehensive service.

It proposed that this should be done by creating a new group, the 'mentally defective'. The Royal Commission, however, did not use

the term in its commonly accepted sense; instead, and somewhat confusingly, it used it in a much broader sense as a generic term for mental disorder. The term lunatic, it proposed, should be discontinued; 'persons of unsound mind' and the 'mentally infirm' would be included in the group mental defectives. It would also comprise those with varying degrees and forms of intellectual impairment: idiots, imbeciles, the feeble-minded and defectives with pronounced anti-social tendencies - 'moral imbeciles' - as well as mentally defective epileptics, inebriates and deaf-mutes. In all, nine categories of the mentally disordered would be included in the broad category of 'mental defectives', thus bringing a much wider range of the mentally disordered under care and control.[96]

The Royal Commission's recommendations therefore implied the re-organisation of both the central and local machinery of the service for the mentally disordered in Scotland. As a corollary to the establishment of a comprehensive service, there was the need to create one central authority for the general protection and supervision of all the mentally disordered, and the particular regulation of their accommodation and maintenance, care, treatment, education, training and control. The authority charged with these functions should, the Commission believed, be a reformed General Board of Lunacy. This Board should, the Commission believed, have a title which would reflect its extended functions, and it recommended the designation 'Board of Control'.[97]

More controversially, perhaps, the Royal Commission also recommended the radical reform of local administration. It was prompted both by a desire to provide new machinery to deal with the wider group for whom local authorities would be responsible, and by

its dissatisfaction with the way in which the existing authorities had performed their functions. Above all it believed that the division of responsibility for the mentally disordered between various local authorities had been harmful, and it was especially critical of the split between the body which maintained pauper lunatics and the body which provided the institutions in which the majority of them were accommodated. It was vital, it believed, to introduce a greater measure of co-ordination, and it proposed, therefore, that all aspects of the care of the mentally disordered should be brought under one authority.

The Royal Commission believed this should be done by extending the powers of district lunacy boards. They would become the sole authority for dealing with the mentally disordered in each district, and the local administration of the service would devolve entirely upon them. This would, the Commission believed, solve many of the service's problems. The charge for the maintenance of the mentally disordered would be removed from the smaller area of the parish to the larger one of the district board, thus relieving small parishes of heavy financial burdens and encouraging the more equitable distribution of financial resources. The district board would be responsible for the ascertainment of the mentally disordered for whom it would be liable, and would be helped by the new statutory obligation of other authorities - including school boards, parish councils, poorhouse governors and the police - to notify it of all cases of mental disorder known to them. The district board would be responsible for making suitable and sufficient provision for the mentally disordered, and for dealing with them, either by registering the case or making arrangements for institutional care or guardianship. The district

board's responsibilities would include mentally defective children; the school board would have control of them only at the district board's request. As in the case of the central authority, this extension of the district board's powers would make its previous designation inapt, and the Commission suggested it be renamed the 'District Board for the Care of Mentally Defective Persons'.[98]

The proposed creation of these new district boards held major implications for the role of the parochial authorities. The Commission recommended that the Inspector of Poor's current statutory functions in respect of the lunatic should be extended to all cases of mental disorder but crucially proposed that their services should be placed at the disposal of the new district boards.[99] Parish councils would, if the Commission's proposals were implemented, have no role to play in the service. It recommended, in fact, that the care of the mentally disordered should be dissociated from the Poor Law, and that the mentally disordered should be 'taken out' of it. They should, in future, be dealt with not as a sub-division of the wider group of paupers, but as a distinct category with its own specialist central and local authority.

The Commission, then, recommended nothing less than the creation of a new service. It proposed that legislation should be introduced to amend the Lunacy Acts and bring them, together with the new provisions for the mentally disordered generally, into one legislative measure.[100] But despite its radicalism, it struck a balance between the perceived and related need to both care for and control the mentally disordered. It did not advocate their wholesale institutionalisation: on the contrary, as has been noted, it supported the large-scale use of boarding out, and was anxious to remove the

barriers which stood in the way of its further development. But it did believe that there was a need for increased intervention to deal with those who were outside the scope of current provision, and who could, in some cases at least, prove a burden or problem for the community. It did not endorse the eugenist position, but neither did it support the continuance of a policy of laissez-faire in respect of a large proportion of the mentally disordered.

The General Board took the opportunity of the publication of the report of the Royal Commission on the Feeble-Minded to add its voice to those calling for reform. It generally welcomed the report and felt that its own suggestions - which were included in its Annual Report for 1908 - were in harmony with its spirit. The Board was also concerned to make the service more comprehensive and urged the amendment of the term 'lunatic' so as to bring a much wider range of the mentally disordered - including 'imbeciles' who were unable to earn their own living - within the scope of the service. Local authorities, it proposed, should be given new responsibilities towards this wider group; district lunacy boards should be empowered to erect institutions for idiot and imbecile pauper children, and parish councils should be required to supervise such children after discharge from the institution. Unlike the Royal Commission, however, it did not appear to support the removal of the mentally disordered from the Poor Law; on the contrary, it apparently envisaged parish councils with expanded obligations in the area. The division of responsibility at local level, it believed, could be solved by making provisions for parish representation on district lunacy boards.

The Board's involvement in almost every facet of the service had given it a special insight into the difficulties which the service

faced and it also provided a detailed list of other amendments, additional to those proposed by the Royal Commission, which it felt were necessary to make reform completely effective. They included a proposal that the procedures for voluntary admission should be modified so as to allow patients to be received immediately upon application, thus eliminating any delay. The provisions governing patients' discharge, it felt, also needed clarification. It also wanted extended powers which would enable it more effectively to perform its functions of safeguarding patients' interests and regulating the institutional service. It recommended that existing provisions for the protection of patients in private dwellings be extended and demanded that it should be empowered to limit the numbers in, and make rules and regulations for, every 'establishment for the insane', including, by implication, Royal asylums.[101]

The future of the service for the mentally disordered was also considered, though from a rather different perspective, by the Royal Commission on the Poor Laws and the Relief of Distress, established in 1905 to inquire into the working of the Poor Laws in the U.K., and to consider whether their legal and administrative modification was needed. Like the Royal Commission on the Feeble-Minded, it also took over three years to complete its task, and reported in 1909. At the end of the investigation four members found themselves unable to agree with their colleagues' recommendations and in the case of Scotland as well as England and Ireland Majority and Minority Reports were issued.

Although the publication of separate Reports was obviously an indication of a considerable degree of dissension, there was, nevertheless, a substantial measure of agreement between the Majority and the Minority on many points; they concurred, for example, on the need

for some sort of reform of the current system, on the abolition of the general mixed poorhouse, and on the important part that voluntary effort could play. Most importantly they were, as regards England and Wales, in harmony on the future of the service for the mentally disordered. Since it was concerned to avoid duplicating or trespassing upon the sphere of the almost simultaneous Royal Commission on the Feeble-Minded, the Poor Law Commission did not undertake any detailed investigation into pauper lunacy. It did, however, comment on the proposals of the Commission on the Feeble-Minded, and, in respect of England and Wales, the Majority and Minority were agreed in echoing its major recommendations that all grades of the mentally disordered should be taken out of the Poor Law.[102] Responsibility for their ascertainment and treatment, the Poor Law Commission recommended, should be placed on the county and county borough councils.

There was an anomaly, however, in the Majority's Report for Scotland, in which it made very little mention of pauper lunatics, and did not make any recommendation as to the authority to which they should be entrusted. There is no obvious explanation for this. The possibility that it simply forgot cannot be discounted. Perhaps the different terms of reference of the Royal Commission on the Feeble-Minded was a contributory factor; the Majority may have felt that by making recommendations on local authorities - which were not specifically mentioned in the narrower Scottish remit of the Commission on the Feeble-Minded - they would have been departing from their avowed policy of only commenting on recommendations which had already been made.

The Minority, however, had no doubt about the Majority's intentions in omitting to include Scotland in its proposal to remove

the mentally disordered from the Poor Law; they concluded that their colleagues intended to leave them as a parish charge. They were outraged by what they saw as the Majority's change of mind; the Minority, at least, had understood that the Poor Law Commission would follow the recommendations of the Royal Commission on the Feeble-Minded as, indeed, both the Majority and Minority had in respect of England and Wales. They were extremely disturbed by what they saw as the Majority's unfair discrimination against the mentally disordered in Scotland and the apparent intention to leave them to the Poor Law was roundly condemned.[103] The Majority did, indeed, appear to be wholly illogical.

The Minority, in contrast, was obviously consistent. No proper treatment of the mentally disordered in Scotland, it felt, could be expected so long as the service for them was so intimately connected to the Poor Law. Thus, as part of their general recommendation for the complete supersession of the Poor Law, they specifically endorsed the proposal of the Royal Commission on the Feeble-Minded to take all grades of the mentally disordered out of the Poor Law. The question of making the maintenance of institutions, and other necessary provisions for them, a national service, the Minority believed, merited serious consideration, but at the very least the responsibility for the treatment, maintenance and control of the mentally disordered should be transferred to a single specialist and preventive authority - like the 'District Boards for the Care of Mentally Defective Persons' proposed by the Royal Commission on the Feeble-minded - in each area.[104]

Although the pressure for reform sprang from a common dissatisfaction with current provision, it would be inaccurate to depict it as a surging tide of uniform opinion. The motives and concerns of

those demanding change were different. Eugenists were driven primarily by the need to halt what they saw as the slide into national debasement, and the welfare of the individual defective or lunatic was, to them, essentially a secondary consideration. To others, the protection and care of the mentally disordered, and, if possible, their education, training or treatment, was the paramount concern. The two attitudes were not mutually exclusive but there was a considerable difference of emphasis at least. There were also several schools of thought on the form of administrative change, particularly on the role of the Poor Law. Nevertheless, in all the investigation and debate of the early years of the century, there was general agreement on the central point that a lunacy service, however structured or administered, was inadequate. Those who took part, whatever their motives or aspirations for the future of the service, concurred that the basis of the service must be widened.

(iii) The Mental Deficiency and Lunacy (Scotland) Act 1913

The pressure for reform had become virtually irresistible. Legislation, however, was not introduced immediately; the Government was preoccupied with many other questions,[105] and mental deficiency was, in any case, a highly complex subject on which to legislate. When a Scottish Bill was introduced it was, originally, tacked onto the English Bill, but it was eventually agreed to have a separate Scottish Bill. The Mental Deficiency and Lunacy (Scotland) Bill was presented to the House of Commons by the Secretary for Scotland in May 1913. It barely scraped through at the end of a crowded session but, despite its somewhat inauspicious start, the Act was the most important mental health legislation for over half a century. It

marked the beginning of general statutory provision for the mentally defective.

Section I divided mental defectives into four groups.[106] These were, firstly, 'idiots': those who were so defective as to be unable to guard themselves against common physical dangers. The next group was 'imbeciles' - those whose defect did not amount to idiocy but which did render them incapable of managing their own affairs or, in the case of children, of being taught to do so. There were, thirdly, the 'feeble-minded' who were neither idiots nor imbeciles but who required care, supervision and control for their own protection, or that of others, or who in the case of children appeared to be permanently incapable of receiving proper benefit from the instruction in an ordinary school. The final category was that of 'moral imbeciles', who exhibited some form of permanent mental defect coupled with strong vicious or criminal propensities upon which punishment had little or no effect.

The Act thus recognised that mental defectives were not a homogeneous group, but comprised those with different grades or degrees of defect. It also reflected the belief that mental deficiency was inherent or congenital, since, in respect of idiots, imbeciles and the feeble-minded, the definition of the condition was qualified by the stipulation that it had to be manifest from birth or from an early age - those who became impaired as a result of illness or injury later in life could not be dealt with under the Act. The exception, the condition of moral imbecility, was required to be evident from childhood. It differed from the other categories in other ways, too. While they were an ascending scale of deficiency, the morally defective group cut across the boundaries of the other categories. While in

the other categories the definition implied that the patient's needs were the primary reason for his being dealt with, the definition of moral imbecility implied that it was the protection of the community from the defective which was paramount. It was a statutory reflection of the widely-held belief that a substantial proportion of the mentally defective were prone to vice.

In contrast to the Lunacy Acts, then, the 1913 Act did at least attempt to provide definitions which could be applied to decide which category the defective should be placed in. But it also illustrated the difficulties inherent in any definition of deficiency. The definitions were not precise, and could be interpreted very differently by different people, in different places and at different times. The sort of behaviour which would justify a diagnosis of moral deficiency, for example, was not explained, and what was seen by one as 'vicious' behaviour another might regard as mere naughtiness. The categorisation of the defective, then, would be largely subjective. Further, while the categorisation decision would be made by medical practitioners, the definitions given were not based on medical criteria; the degree of intellectual impairment was to be deduced from the patient's social performance, in which field doctors had no special expertise.

The Act distinguished between defectives who could pay for themselves, or whose relatives could maintain them, and those who required to be maintained at public expense. For those in the first group, it laid upon the parent or guardian the duty to provide for the education, or the proper care and supervision, of defectives aged 5-16. If the defective was educable, this duty could be met by making arrangements for education at a special school or class. Otherwise, if the defective was ineducable or over sixteen, he could be placed in

an institution or under guardianship. But the Act drew a distinction between those who could be so placed at the instance of their parent or guardian, and those for whom judicial authority would have to be sought. Idiots and imbeciles could, whatever their age, be dealt with at the instance of their parents or guardians, while feeble-minded defectives and moral imbeciles could be dealt with at the instance of their parent (but not of their guardian) if they were under twenty-one. No judicial order was required for such cases, though medical certificates and the General Board's sanction were necessary. Where a defective was placed under care at the instance of parents or guardians, they could withdraw him or her from such care at any time, provided that notice was given to the General Board, unless the Board determined that further detention was required, in which case the parent or guardian could not give notice of withdrawal for another year.

Mental defectives who required to be maintained at public expense were, throughout the Act and subsequently, referred to as 'rate-aided' rather than 'pauper' defectives, even though parish councils would have the same responsibility for their maintenance as for pauper lunatics; the term was, perhaps, a sign of greater sensitivity towards the derogatory connotations of the term 'pauper'. Rate-aided defectives were to be dealt with at the instance of the local authority concerned.

The local authority which was concerned depended on both the age and status of the mental defective. In the case of defectives under sixteen, the school board was the local authority initially concerned in all cases; it was required to ascertain juvenile defectives, and to assess those who were educable and those who were not.

In the case of the former, the school board was required to make provision for education in a special school or class, or in an institution. If the defective was deemed to be ineducable, however, the school board was required to intimate the case to the parish council (and the General Board), for while it had originally been proposed that the school board would deal with all juvenile defectives, the possible loss of the Bill on this point resulted in its amendment. In ineducable cases, therefore, the school board's duty to make provision was transferred to the parish council. Whether educable or ineducable, a juvenile defective could, with the consent of the parent or guardian, be dealt with on the authority of medical certificates and the sanction of the Board without a judicial order. But, by entrusting the educable and ineducable to two different local authorities, and by excluding the ineducable from the school system, the 1913 Act underlined the distinction, made in the 1906 Education Act, between defective children who were deemed capable of learning and those who were not.

All the foregoing powers of local authorities in juvenile rate-aided cases were based on the assumption that the parents' or guardians' consent was obtained. Such consent was, in fact, essential, since, in the case of all juvenile defectives for whom local authorities were responsible, it normally had to be obtained before the juvenile could be dealt with. If it was not given, the local authorities' options were limited. If there was no parent or guardian, if consent was, in the local authorities' view, unreasonably withheld to the detriment of the child, or if the child was neglected or cruelly treated or fell into any other of a number of categories specified under section 3(c) of the Act, the local authority could

petition the Sheriff for a judicial order to deal with the child. But it would still be possible for the parent or guardian to thwart such a move, since an order could not be granted without supporting medical certificates, and parental consent was required before a medical examination could be undertaken. The consent of the juvenile's parent or guardian, then, would be necessary for the effective working of the machinery of the Act.

In addition to their responsibilities towards ineducable juveniles, parish councils were also given important powers in respect of defectives over sixteen. They were obliged to ascertain those over that age (other than those who could be dealt with at the instance of their parents) who were mental defectives subject to the provisions of the Act, and to take steps to place them in an institution or under guardianship. However, those over sixteen who were subject to be dealt with were a limited group. They had, in addition to being defective, to fall into one of the categories of section 3(c) of the Act. One of these was school leavers who were reported to the parish council, by the school board, as requiring further care. Some related to defectives who required to be dealt with in their own interests.[107] Yet others were cases in which the adult defective was a social burden or menace, because they were guilty of a prisonable offence, habitual drunkards,[108] unmarried mothers who were 'on the parish', or habitual paupers.[109] Again, the requirement for a judicial order was dependent upon the defective's age and parental consent. Those under twenty-one could, with parental consent, be dealt with without an order. In all other cases, however, an order had to be sought.

In the case of defectives over sixteen, then, mental defect alone was not sufficient grounds for the defective to be dealt with;

other circumstances and other criteria, which were not directly related to his degree of intellectual impairment, would be taken into account. Whether or not an adult defective was liable to be dealt with under the Act would depend on his personal, economic and social circumstances rather than his medical condition. The fact that no feeble-minded defective or moral imbecile over twenty-one could be dealt with without a judicial order regardless of whether they were rate-aided or private defectives was a recognition of the potential danger inherent in the extension of provision to higher-grade defectives, since the necessity to obtain an order was intended to guard against the possibility of the institutionalisation of a person who was merely troublesome.

When a judicial order was to be obtained, the same tripartite authority of petition, certificates and order would be required for mental defectives as for lunatics. The petitioner could be the defective's parent or guardian, the local authority, the procurator fiscal or the General Board. One of the certifying doctors would have to be approved by the Board. But the procedure for a mental defective's detention would differ in a very significant way. In their case, the Sheriff would have the same powers - including those relating to the summoning and examination of witnesses, and the administration of oaths - as if he were acting in the exercise of his ordinary civil jurisdiction. This was in sharp contrast to the more or less routine performance of the Sheriff in granting an order for a lunatic. The granting of an order for a defective would be a judicial process, and the Sheriff could require the attendance in court of the doctors granting the certificates, make any inquiries about the case, and give relatives - or even the defective himself - the opportunity

to oppose the petition.

The authority for the detention of a mental defective was also for a limited period of time. With only two exceptions, the authority for the action expired after one year, although it could be renewed for a further year if the General Board, on the evidence of a medical report and further certificate, felt that the circumstances warranted continuation. Review took place again at the end of the second year of detention and, if the defective was not then discharged, subsequently at three-year intervals. The exceptions to these legal procedures was firstly if the defective was under twenty-one when placed under care; then the authority for detention lapsed automatically when he or she attained the age of majority. Secondly, if the defective was placed under care by a school board with the consent of the parent or guardian, the authority for detention did not cease until the defective reached the age of sixteen.

The Act also provided for the establishment of new forms of institutional provision for mental defectives. Certified institutions could be provided either by the statutory sector or by voluntary associations. In the case of the former, district boards were to be responsible for their erection or acquisition. As in the case of district asylums, which certified institutions provided by district boards to some extent paralleled, the sites, plans, estimates and other proposals had to be submitted to the General Board for sanction. District boards would also be responsible for the management of the certified institutions that they established, for appointing and paying their staff, regularly inspecting them and generally seeing that patients were adequately treated and cared for. It was also envisaged that local authorities would make contracts for the reception of rate-

aided defectives into voluntary certified institutions, in the same way as they currently did in respect of Larbert and Baldovan Institutions.

The new mental deficiency service, however, like the lunacy service, included provision for care outside institutions. It provided for the establishment of 'certified houses' for the reception, for profit, of private patients, and for the reception of rate-aided patients into single care and into licensed houses licensed to accommodate a maximum of four patients. 'Congenital imbeciles' had, of course, long been received into private dwellings but they would, henceforward, be dealt with as mental defectives rather than as lunatics.

The creation of a mental deficiency service also required the creation of a new central independent statutory body to supervise it. The General Board of Commissioners in Lunacy for Scotland was therefore abolished and the new General Board of Control for Scotland established; it had a similar composition to its predecessor, but there was the addition of a third Medical Commissioner (and not more than four medical Deputy Commissioners, at least one of them a woman). The designation of the new General Board, and its extended membership, reflected its expanded range of functions. In addition to its inherited powers, it was entrusted with the exercise of general superintendence over mental defectives and the institutions provided for them. Its duties included the supervision and protection of defectives; the co-ordination and supervision of the administration of local authorities; the certification and inspection of institutions, houses and private dwellings for the reception of defectives; the visitation of all defectives placed under care under the Act; and the

administration of the grants provided by Parliament under the Act. It was broadly charged with a similar combination of administrative and liberty-of-the-subject functions as its predecessor, but in respect of a much wider group.

The General Board would be intimately concerned in almost every aspect of the 'career' of mental defectives. In respect of their admission to care, the Board's chief role would be to enforce satisfactory standards among certifying doctors by approving them, but in some circumstances the Board itself could arrange for the defective's placement in an institution or under guardianship.[110] It could also order the transfer to a mental deficiency institution of a defective under guardianship by judicial order, or a defective in an asylum, although it had no power to order transfer where guardianship was by the consent of the parent or guardian. Nor, in an apparent oversight, was it empowered, in any case, to order transfer from an institution to guardianship. Finally, in respect of a defective's discharge, the Board's sanction would be required for an absence from an institution of longer than a fortnight, and in contrast to lunatics, who were frequently discharged by relatives or, in pauper cases, by minute of the parish council, the Act appeared to limit the power to permanently discharge certified defectives from care to the General Board alone.

In general, the inauguration of the mental deficiency service entailed a considerable administrative readjustment. The district lunacy boards were, in fact, abolished, and replaced by 'district boards of control'. The composition of these new bodies differed from that of their predecessors in a very significant respect; parochial authorities were represented on them. One-third of the members of the district boards were to be elected by the chairmen of all parish

councils within the lunacy district. The aim was to remove the resentment which had been engendered by the parish councils' lack of say in the management of institutions in which the majority of inmates were maintained at their expense.

The Act also attempted to redress another of the grievances of parish councils by alleviating the financial burden of the mentally disordered. District boards were held to be primarily responsible for pauper lunatics in asylums and rate-aided defectives in certified institutions, while parish councils were primarily responsible for pauper lunatics under guardianship and in lunatic wards, and rate-aided defectives under guardianship. The parish council or district board would initially pay the full cost of maintaining those for whom it was primarily responsible, but would subsequently recover half of it from the parish council or district board which was jointly liable. Half the cost of maintaining the mentally disordered was thus removed from the parish and transferred to the county and burgh rates. Local authorities would, further, receive an annual grant from Parliament for mental deficiency purposes. A ceiling of £20,000 was put on it, and local authorities would not be obliged to maintain or provide for defectives if the contribution from this source fell below half of their legitimate expenditure.

While the cornerstone of the 1913 Act was the provision that it made for mental defectives, it also made modifications to the lunacy service. In addition to the reform of its financial basis, administrative changes were also made. The General Board's powers over the institutional service were strengthened; henceforward, the sites, plans, specifications and estimates of all asylums would be subject to the Board's approval. It was also empowered to limit the

number of patients in any asylum, and the rate of board for private patients admitted to district asylums - for which the Act made extended provision - was to be subject to the Board's approval. The Board's power over Royal asylums, however, was, though extended by the Act, still limited. The concerted lobbying which the authorities of Royal asylums had undertaken during the passage of the Bill had succeeded, to a large extent, in preserving their freedom of action, and the General Board would still have no power to make rules and regulations for Royal asylums.[111]

The Act also remedied some of the deficiencies that experience had highlighted. The delay between an application for voluntary treatment and its commencement was eliminated by its provision that a voluntary patient could be admitted immediately upon application, provided that the sanction of the General Board was sought immediately afterward. The Act also provided for more flexibility in the placement of certified patients; the General Board's power to sanction the transfer of patients from one asylum to another was extended to cover transfers from asylums to lunatic wards and private guardianship, and the replacement of the patient in the asylum, without the lapsing of the Sheriff's order. It also strengthened the Board's powers to safeguard the interests of private patients under the care of their natural guardians in private dwellings. Extended powers were given to the Commissioners to visit any place where they believed that a person was illegally detained, and it extended the provisions for the protection of those who were harshly or cruelly treated, neglected or exposed to sexual danger or immorality.

It is difficult to summarise these complex and detailed legal changes. In essence, however, a new service which had many

similarities to the lunacy service, but which differed from it, had been established. The diversity of reformist opinion meant that the Act could not satisfy all the demands which had been made. Parish councils, contrary to the recommendations of the Royal Commission on the Feeble-Minded and the Minority Report of the Poor Law Commission, had not been relieved of their responsibilities for the mentally disordered; indeed, they would in some respects have an extended role to play. Nor had the Act made any concessions to the sterilisation lobby. The General Board's powers in respect of Royal asylums would still be limited. On the positive side, however, many demands had been met. The categories of mental defective recognised by the Act were the four main groups identified by the Royal Commission on the Feeble-Minded, and the specialist central and local authorities had been given extended powers. Parish councils, too, would no longer carry the burden of the pauper lunatic alone, and would have a voice on district boards. Some of the General Board's suggestions had been incorporated into the legislation; most importantly, perhaps, voluntary admission had been simplified. Eugenists could also feel satisfied with the inclusion of the category of 'moral imbeciles'. Above all, the chief demand of all those calling for reform - the extension of the scope of the service to a much wider group - had been met, and a service for the mentally disordered had replaced the lunacy service.

The Act came into force in May 1914 and by the end of the year 295 certified mental defectives were on the General Board's register. Most of the cases reported to the Board by parish councils and school boards had been visited by its Commissioners, and 89 aided defectives had been certified and placed under guardianship.[112] The existing institutions at Larbert and Baldovan were, under the terms of the Act,

redesignated as 'Certified Institutions for the Care and Treatment of Juvenile Defectives', and during 1914 some new mental deficiency accommodation was provided. Waverley Park Home, Kirkintilloch, which was provided by the Glasgow Association for the Care of the Feeble-Minded, was certified for the reception of educable juvenile females, and three other institutions were certified for adult defectives. Grierson Hall - attached to the Crichton Royal Institution - and Middleton Hall - a mansion near Uphall, certified on the application of Edinburgh District Board of Control - were both relatively small. Stoneyetts Institution, however, was, with Larbert, the largest mental deficiency institution in Scotland; it was a new institution which had been built by Glasgow Parish Council as an epileptic colony but, following the 1913 Act, it was transferred to the District Board of Control and its 345 beds used for mental defectives.[113]

However, problems were soon evident. Despite the new mental deficiency accommodation which had been provided, it was glaringly apparent that demand far outstripped supply. Larbert Institution, for example, was so overwhelmed by applications from local authorities that a waiting list was compiled, and in some cases where children urgently needed to be removed from their homes, no action could be taken because no beds were available. Parental non-co-operation, too, was already thwarting attempts to provide institutional care.[114] It was too soon to tell whether these difficulties were 'teething troubles' or more permanent problems, but these were early days and it seemed that problems might, with experience, soon be ironed out. In fact, however, the reverse was true. A few months after the Act came into force, the service for the mentally disordered would be faced by new and unforeseen complications.

Chapter 2 War-Time Dislocation

(i) The effects of war upon the lunacy service

(ii) War and the nation's mental health

(iii) The mental deficiency service

The outbreak of war in August 1914 was the beginning of a period of severe disruption in the service for the mentally disordered in Scotland. Those who were in the throes of implementing the new legislation also had to contend with the effects of the first total war. This chapter discusses the provisions made for mentally disordered servicemen, and the impact of war upon civilian asylums. It also considers the complex question of the effect of war upon the mental health of the community as a whole. Finally, it describes how provision for mental defectives under the 1913 Act was checked whilst still in an embryonic stage.

(i) The effects of war upon the lunacy service

A chief concern of some asylums during the early months of the war was invasion,[1] but as the immediate threat of it receded more pressing questions engaged the attention of those involved in the service. Chief among them was the problem of how to deal with mentally disordered servicemen. There was a considerable body of public opinion which held that servicemen should not be admitted to ordinary asylums lest their recovery be retarded by proximity to lunatics. But there was an even more general conviction that if they were to be so admitted, it must not be as paupers.[2] The unacceptable pauperisation of those who, as the public saw it, had become insane in the service of their country was temporarily avoided when some institutions, like the Edinburgh Royal Asylum, received N.C.O.s and men gratuitously.[3]

However, this could only be a short-term expedient. Asylums were not prepared to bear the financial burden indefinitely. Nor were the military authorities anxious to send patients to them; while

the Crichton Royal Institution, for example, had within days of the outbreak of war offered to receive and maintain servicemen free of charge,[4] the War Office and the Admiralty seemed reluctant to take it up. One reason was that it took time for mentally disordered servicemen to appear in any numbers. But it was also because the military authorities were influenced by the public sentiment against asylums: indeed it was on those grounds that the Crichton Royal's offer was in 1915 politely declined.[5] It was obvious that the treatment of mentally disordered servicemen would have to be placed on a more regular footing.

One solution was the opening of special mental hospitals for servicemen. From 1915 onwards, many servicemen with mental and nervous disorders were treated, without being pauperised or certified, in military mental hospitals run by the War Office; Renfrew District Asylum was among the institutions taken over for the purpose. But it was impracticable to accommodate all mentally disordered servicemen in separate institutions, and the problem of the pauperisation of those who remained in ordinary asylums still persisted. The answer came with the introduction of the 'service patient' system. From 1 August 1917, servicemen were, as service patients, maintained as private patients by the Ministry of Pensions which, in addition to paying for their upkeep, provided an extra allowance for pocket money and for the provision of clothes different to those of the ordinary asylum inmates; while service patients were accommodated in the same institutions as paupers they were, significantly, physically distinguished from them. The arrangement was generally welcomed as 'the best practical solution of a difficult problem',[6] particularly when two possible objections to it - the fact that service patients

still had to be admitted as paupers before being reclassified, and the necessity for their certification - were subsequently removed.[7]

In some cases, indeed, the special provision under which they were treated was the only factor which distinguished servicemen from other patients. Contrary to public opinion, many mentally disordered servicemen were not victims of shell-shock or, indeed, of war at all. Some had seen active service but others, like the majority of those admitted to Edinburgh Royal Asylum in 1915, had not been to the front. Others had never been abroad. Some suffered from 'ordinary' mental illnesses, while others were high-grade mental defectives whose condition had not been identified until after enlistment.[8]

It was, perhaps, unduly prophetic of Dr. Reid, Superintendent of Aberdeen Royal Asylum, to assert that the 'natural instability' of many of these cases would have resulted in mental illness even if there had been no war:[9] the prospect of battle could make breakdown more likely even in the case of a serviceman who had not heard a shot fired in anger. Nor should the prevalence of shell-shock be minimised, for many of its victims were treated in military hospitals. Nevertheless, although shell-shock, with its dramatic connotations, captured the public imagination, it is apparent that many servicemen suffered from the rather less 'romantic' conditions of general paralysis, schizophrenia and mental enfeeblement. Their division into those whose condition was attributable to, or aggravated by, military service, and those whose condition was not,[10] was, indeed, official recognition that war service in many cases revealed rather than directly caused mental disorder.

The treatment of service patients in ordinary asylums, therefore, did not generally present any particular medical problem.

However, the asylums still had to find room for them. Further, the opening of war hospitals, though relieving asylums of the necessity to accommodate some servicemen, caused more problems than it relieved. Many beds were required for sick and wounded servicemen, and many of them were found in asylums. In most cases, requests from the military authorities for asylum beds were readily acceded to. In other cases, however, the asylum authorities were reluctant to comply - indeed, in 1916 Govan District Board of Control declined a request to hand over the District Asylum for military use.[11] But although the War Office did not invoke it in this instance it could, if necessary, commandeer an institution. Resistance was, in the final analysis, fruitless.

More or less willingly, then, a number of asylums were evacuated and converted into military hospitals. They included two of the most modern asylums in the country - Edinburgh District Asylum and Renfrew District Asylum, Dykebar - as well as the older Perth and Stirling District Asylums. Many civilian patients were displaced. Transfer was particularly traumatic for long-stay patients for whom the asylums had been 'home' for many years. In some instances - as in the case of Bangour patients transferred to Aberdeen Royal Asylum and Stirling patients removed to the Crichton Royal Institution, Dumfries - they were resettled a considerable distance away from their homes and thus from family and friends.

The effect of the conversion of asylums into war hospitals was not, however, confined to those patients who were most directly involved. It had a considerable impact on other asylums which, though already in some cases accommodating servicemen, were further obliged to cope with another wave of patients evicted from asylums

taken over by the military authorities. Some were, unsurprisingly, reluctant to agree, and some friction resulted; the managers of the Crichton Royal were particularly irritated by the General Board's heavy-handedness when, in 1915, it backed up its request for the Institution to receive patients from Dykebar with a reminder of the War Office's powers of compulsion.[12] In such circumstances, the Crichton Royal, like other institutions, had little option but to agree. All the receiving asylums experienced considerable difficulty in accommodating the transferred patients and in finding room for all the new cases from the areas where the district asylum was no longer available.[13]

Moreover, an already exceptionally difficult situation was compounded by an acute and virtually universal shortage of staff, which began on the outbreak of the war and lasted for its duration. Its primary cause was the loss of staff to the war effort. Substantial numbers of staff - from superintendents to artisans - immediately enlisted. At the Crichton Royal Institution, for example, three medical assistants, two assistant matrons, twenty-four attendants and numerous anciliary staff joined up in the first six months of the war,[14] while at the Edinburgh Royal Asylum, forty-five members of staff had answered 'the call of the country' by the end of 1914; by the end of 1915, only one experienced medical officer (out of four pre-war) was left at the Asylum, and nearly half of the matrons and assistant matrons had gone.[15] At the Crichton Royal, the pre-war complement of seventy-six attendants had dropped to fifty by the end of 1915.[16] The pattern was repeated in every institution. The General Board intervened and arranged with the War Office that asylum employees could be exempted from military service if they were

deemed indispensable, but while some applications for exemption were submitted to the local tribunals which dealt with the matter, other asylums were reluctant to do so.[17]

It was virtually impossible to find men to fill the vacancies caused by the depletion of staff, since those men who were not in the forces had little incentive to enter asylum work; higher wages and more congenial conditions were available elsewhere. The male attendants who remained were generally over military age, unfit for the services, or conscientious objectors. In many cases, a reduced and largely inexperienced staff had to cope with an increased number of patients. The strain that the situation placed on those who were left was recognised by Dr. Robertson when he asserted that those who stayed at their posts were as worthy of praise as those who felt they must go.[18]

But while the shortage of male staff posed serious problems, the situation would have been intolerable if it had not been for the increased use of women to nurse male patients. The employment of females on male wards had, even before the war, been more extensively practised in Scots asylums than in English ones. Doubts about its advisability still lingered and in 1916 it was still felt necessary to stress that women nursing men were not liable to suffer 'in a moral sense'.[19] By that time, however, the pressing necessity for more staff had overridden any remaining objections and in asylums, as in other walks of life, women were occupying positions which had previously been considered to be men's jobs. By the end of 1915, 150 of the 200 nurses at the Crichton Royal Institution were women, and many of them were nursing men,[20] while at Aberdeen Royal Asylum, female nurses had been appointed for almost the entire care of sick,

infirm and senile men.[21] This expansion of female nursing was reflected in the service as a whole.

The widespread adoption of female nursing of male patients was widely praised by many asylum superintendents. Women, it was claimed, were often better nurses than men and, in particular, had a civilising influence on male patients who 'even in the depths of mental illness, retain and observe the courtesies and proprieties towards the gentler sex'.[22] But there were some problems. Many male cases - including general paralytics, paranoics and most adolescents - were generally felt to be unsuitable for female nurses, and women did not normally work on the wards which contained the more disturbed and deteriorated male patients. There were also recruitment difficulties, since women, like men, were drawn to the greater pecuniary attractions of other work, particularly in munitions. As the war went on, some institutions found it increasingly difficult to find suitable women.

In a further attempt to remedy the shortage, the War Office in 1917 agreed to provide asylums with some Royal Army Medical Corps orderlies who were no longer fit for active service, and they acted as temporary attendants in a number of institutions; more were supplied in 1918.[23] This expedient, however, could not compensate for the chronic scarcity of experienced attendants. Nor, because of the limitations placed on their role, could female nurses. While, in the longer term, the war-time expansion of the scope of female nursing became a permanent feature of provision, in the short-term it barely enabled some asylums to avoid a complete breakdown in the nursing service.

The institutional service also had to contend with financial

problems. The disruption of markets and transportation difficulties caused inflationary price rises, and as a result some asylums had to raise their rates of board to cover the increased costs of maintenance - indeed, the Crichton Royal Institution increased charges twice in 1914, and at least once in every subsequent year of the war.[24] Royal asylums also suffered when, because of the pressure of pauper patients transferred from war hospitals, they had to refuse admittance to some private patients. Consequently, economy became the watchword, and every effort was made to minimise expenditure.

The general disruption that the war entailed also caused some supply difficulties. Some foodstuffs became scarce, while the quality of others was reduced. Many asylums, however, were cushioned against the worst effects of the shortage by the produce which they obtained from their own farms.[25] Even after compulsory rationing replaced voluntary self-rationing in 1918, the body weight of asylum patients was, on the whole, maintained,[25] but the effects of the wartime diet on patients' health may have been more insidious, and may even have been one of the factors which contributed to the increased death rate of asylum patients.[27] *

The immediate effect of the war on the asylum service, therefore, was a negative one. Overcrowding, staff shortages, economic and supply difficulties placed a heavy burden upon asylum authorities and staff, and adversely affected the quality of life of patients. Hardship, however, was not evenly distributed. It was district asylums, which accommodated mainly pauper patients, which were evacuated for military purposes, and it was pauper patients who suffered when the patients displaced from the asylums were transferred to other district asylums and to the pauper sections of

* 24 Table 2:4

Royal asylums. Private patients were not entirely insulated from the disruption, but the subordination of the needs of the civilian asylum service to the demands of the war effort undoubtedly bore more heavily upon rate-aided cases.

Nevertheless there was from early in the course of the war an expectation that it might have a more positive effect on the service in the longer term. The conversion of asylums into War Hospitals under the charge of the usual superintendent meant that they gained experience of managing their institutions on hospital lines, and Dr. Robertson was among those who felt that it would inevitably colour the superintendents' methods when the institutions reverted to their original purpose.[28] Indeed, the impact of the treatment, in Military Mental Hospitals and civilian asylums, of many uncertified servicemen was already apparent during the war. It demonstrated that treatment without certification was possible on a larger scale than hitherto, and in particular highlighted the injustice of denying the vast majority of civilian patients the same opportunity. Several asylum superintendents commented unfavourably on the contrast,[29] and it appeared likely that, in the future, the pressure for the extension of voluntary treatment to paupers would increase as a result.

Moreover, it also seemed that the treatment of servicemen might have medical repercussions. The experience of dealing with shell-shock focused attention on the need for further research into the still obscure causation of much mental illness, and some doctors, like James MacDonald of Govan District Asylum, felt that the war might stimulate an increase in the 'infinitesimal' funds currently devoted to it.[30] Further, the treatment of shell-shock seemed to some to point towards the direction that future research should take.

To Dr. Robertson, it indicated that psychological rather than organic factors lay behind much mental illness, and he suggested that research should not be concentrated on largely fruitless investigations of the brain but on the mental processes, or emotional aspects, of disorder.[31]

The war did not by itself create the demand for the more widespread adoption of voluntary treatment and more research, but in these respects, as in others, it spotlighted the shortcomings of the service and telescoped into a few years lessons that might otherwise have taken much longer to learn. Many hoped that some of the expedients which were a response to the exigencies of war might, like the improved amenities provided in asylums which became military hospitals, become a permanent part of peacetime provision.

(ii) War and the nation's mental health

While the war had positive side effects upon the institutional service, there was evidence which suggested that it had a similar impact upon the community as a whole. There had, on the outbreak of war, been some apprehension as to its possible effect upon the nation's mental health.[32] World War One - in terms of the loss of life, conscription and rationing - undoubtedly had a greater effect on the civilian population generally than had any previous conflict. But were the fears about its adverse influence on the incidence of mental disorder in the community justified?

The war did appear to be at least a contributory cause of some mental disorder. Dr. Reid believed thatit produced in some patients 'a self-centred, apprehensive, depressed, fanciful, sleepless and fatigued condition',[33] while Dr. Oswald of Glasgow Royal Asylum felt

that in some women of 'high character', the war led to 'morbid depression ... allied to insanity'.[34] 'War delusions' were reported from Edinburgh Royal Asylum in 1914.[35] But while the effect of war was often discussed in rather general terms, it was specifically stated to have been a direct influence on the onset of mental breakdown in the case of a number of patients admitted to Scots asylums.[36] Whether because of anxiety about relatives in the forces, grief at bereavement, overwork or distress at the 'barbarous conduct' of the enemy,[37] the war appeared to have a deleterious impact upon the mental health of some civilians.

But this must be put into perspective. Attribution of the cause of mental disorder rested heavily on relatives' accounts of the patient's previous history and, as Dr. Robertson recognised, relatives were often anxious to find the most comfortable explanation for the attack. The war was 'conveniently and obviously at hand' for this purpose,[38] and it was almost certainly sometimes used as a scapegoat for mental disorder which was due to some other cause.[39] One of these other causes, many doctors stressed, was some inherent, and often hereditary, weakness. Even in cases in which the war was acknowledged to have played a part, constitutional nervous or mental instability was usually thought to be also present. There was a general feeling that while war coloured the symptoms of some patients and exposed and accentuated the condition of others, it did not, in general, produce mental breakdown in hitherto healthy subjects.[40] Finally, the number of cases of mental disorder which were caused by, or even exacerbated by, the war appeared to be small.

In general, then, the war did not appear to cause much mental disorder, and the national mental crisis which some had feared did

Table 2:1 Lunatic Admissions, 1914-18

A. Admissions to Institutions

Year	Private	Pauper	Total
1914	569	3186	3755
1915	548	3059	3607
1916	561	2874	3435
1917	528	2609	3137
1918	779	2614	3393

B. Admissions to Private Dwellings

Year	Total (Paupers)*
1914	214
1915	193
1916	210
1917	139
1918	121

* The number of private patients in private dwellings who were known to the Board was so small that no annual admissions figures were given.

C. Voluntary Admissions to Institutions

Year	Total
1914	181
1915	146
1916	185
1917	186
1918	172

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Source: Annual Reports of the General Board of Control for Scotland

Table 2:2 Lunatics Known to the Central Department*, 1914-19

On 1 Jan.	Private	Pauper	State	Total
1914	2624	16660	62	19346
1915	2621	16870	66	19557
1916	2565	16480	63	19108
1917	2530	16289	66	18885
1918	2553	15711	62	18326
1919	2771	14927	67	17765

* Including the inmates of the Criminal Lunatic Department of Perth Prison and the inmates of Training Schools for Imbecile Children who were not certified under the Mental Deficiency Act 1913.

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland and of the General Board of Control for Scotland

not materialise. Indeed, the reverse appeared to be the case. Many asylums began to experience a fall in admissions.[41] The seeming improbability of this caused many asylum superintendents to check that the trend was not confined to their area, but like Dr. MacDonald they found that a similar reduction seemed to have occurred 'in other districts throughout the country'.[42] There were exceptions to the general pattern, but they were usually due to some special cause - the increase in admissions to the Crichton Royal Institution, for instance, was almost certainly the result of the influx of population into the area because of the opening of the giant munitions factory at Gretna. Nevertheless, despite being largely insulated from first-hand experience of the phenomenon, Dr. Easterbrook could not fail to be aware of the 'striking diminution' in admissions which had generally taken place elsewhere.[43]

The trend was indeed reflected at a national level. The number of lunatics admitted to institutions fell (Table 2:1). In the case of voluntary admissions, and private admissions generally, the pattern was a fluctuating one, but there was a substantial fall in pauper admissions. There was also a fall - though not an uninterrupted one - in annual admissions to private dwellings.[44*] The decrease in admissions was, in turn, at least partly responsible for the overall decrease in numbers. In January 1916 the General Board reported the first absolute decrease in all categories of the insane - pauper and private, male and female, known and registered - since 1857, and in the years which followed the overall trend, despite minor deviations, was clearly downwards.[45] By January 1919 the number of known lunatics was some fifteen hundred below the total of five years earlier.[46]

*44 Table 2:1(B)
*45 Table 2:2
*46 Table 2:2

Table 2:3 Registered Lunatics*, 1914-19

On 1 Jan.	Private	Pauper	Total
1914	2464	16218	18682
1915	2495	16476	18971
1916	2465	16377	18842
1917	2445	16216	18661
1918	1478	15647	18125
1919	2704	14897	17601

* Excluding the inmates of the Criminal Lunatic Department of Perth Prison and of Training Schools for Imbecile Children.

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland and of the General Board of Control for Scotland

Table 2:4 Deaths in Establishments for Lunatics, 1914-18

Year	Private	Pauper	Deaths as a Percentage of the average number resident for the year
1914	188	1345	9.6
1915	223	1574	11.0
1916	226	1536	11.0
1917	285	1616	12.1
1918	350	1896	14.6

Source: Annual Reports of the General Board of Control for Scotland

Did this evidence, then, prove that it was 'indisputable that insanity lessened during ... the war'?[47] Most commentators were cautious and there were indeed several factors, other than an actual decrease in insanity, which contributed to the trend. The reduction in the number of known lunatics is less persuasive than it might appear to be. Firstly, known lunatics had previously included some mental defectives - the inmates of training schools for imbecile children and those in private dwellings - who were, after the 1913 Act, generally dealt with as mental defectives, and so did not come onto the lunacy statistics.[48] Much of the fall in the early part of the war would seem to be due to this administrative change,[49] although it could not fully account for the continuing drop, nor for the fall in numbers of registered lunatics (Table 2:3) among whom training school inmates had never been included . But another factor which did contribute to the decrease in known lunatics was the increase in the number of deaths in asylums during the war.[50] *

The fall in the number of admissions, however, appeared to offer stronger grounds for the conclusion that lunacy was really decreasing, for while the operation of the 1913 Act could, again, account for some of the initial decrease, it could not fully explain its continuation. But the general disruption of the service may have meant that more lunatics simply slipped through the net. The disruption of family life, and particularly the increase in the number of women at work, was, perhaps, a factor in the fall in admissions to private dwellings; the fall in unemployment also meant that the extra income which guardianship offered was less necessary. Above all, however, there was the number of men in the forces. This reduced the male population and meant that some cases of mental disorder which

* 50 Table 2:4

Table 2:5 Registered Lunatics by Gender, 1914-19

On 1 Jan.	Males	Females			Grand Total
		Private	Pauper	Total	
1914	9212	1390	8080	9470	18682
1915	9395	1409	8167	9576	18971
1916	9304	1389	8149	9538	18842
1917	9258	1370	8033	9403	18661
1918	8959	1345	7821	9166	18125
1919	8582	1391	7628	9019	17601

Source: Annual Reports of the General Board of Commissioners in Lunacy for Scotland and of the General Board of Control for Scotland

would, in normal circumstances, have come on to the Board's register were dealt with in military hospitals and escaped the statistics. Without accurate information about the incidence of mental disorder in the forces, it was very difficult to be dogmatic about a decrease in insanity among men.

However, the decrease registered in female lunacy[51]* could not be attributed to military service. It was partly because of this less easily explainable reduction that the belief in a real decrease in insanity persisted. But there was also, perhaps, a need to believe it. The question of the nation's mental health carried serious implications for morale. It would not have been conducive to the war effort, and might even have been deemed to be verging on the treasonable, to suggest that the civilian population was not capable of taking the strain. The suggestion that it was only the congenitally unstable, or those already teetering on the brink of breakdown, who were suffering, and that the mental fibre of the community in general was bearing up well - and was even being strengthened - was, obviously, the more patriotic approach.

Echoes of this were, indeed, obvious in doctors' explanations for the apparent diminution in insanity. Some of those who had, only a few years before, been vehement supporters of the concept that the race was being fatally undermined by mental deterioration became equally enthusiastic proponents of the nation's current mental resolution. It was frequently suggested that the war was a purifying process and was acting as 'a mental tonic'.[52] It was seen as encouraging the re-emergence of dormant strength, and as bringing out 'those qualities of the race which won us our Empire in the past'.[53] A new spirit of willing sacrifice and unity of purpose was often

*51 Table 2:5

described - war had 'put self into the background' and 'taken people out of themselves'.[54] The community's attention, it was felt, was being redirected away from the petty worries of everyday life towards the necessities of the national crisis.

The bracing effect of the war was felt to be especially marked in the case of middle and upper-class women. The increased opportunities it offered for social and philanthropic endeavours, or even for work outside the home, was hailed as liberating. Although women who had previously led sedentary lives might occasionally break down under the strain of unaccustomed activity, occupation was generally felt to be much less injurious than the 'semi-employed and shut-in lives'[55] that many of them had previously led.

The increased opportunities for employment offered by the war were also thought to be advantageous for working-class women, although in their case the benefits were primarily economic. The virtual disappearance of unemployment, coupled with higher wages, increased the prosperity - or at least relieved the abject poverty - of the working class, thus alleviating some of the domestic anxiety which might contribute to mental disorder. The fact that women had fewer financial sorrows to drown may have been partly responsible for the decline in the amount of alcoholic insanity among females,[56] although restrictions on the availability of alcohol probably also contributed.

But although the decline in the number of registered female lunatics provides the most persuasive evidence for a real decrease in insanity during the war, it is, in the final analysis, almost impossible to come to any firm conclusion about the effect of war on the mental well-being of the community in general. It is extremely

difficult to evaluate the relative significance of the demographic and administrative factors which tended to decrease the numbers of known lunatics and the social, economic and 'psychological' factors which may have tended to decrease insanity itself. Whether the war merely obscured the real level of insanity, or whether it temporarily halted, or even reversed, the seemingly inexorable increase in the number of the insane remains open to question.

(iii) The mental deficiency service

The mental deficiency service shared many of the problems of the lunacy service; both suffered from staff shortages, the effects of inflation and supply difficulties. The mental deficiency service also suffered, though in a less direct way,[57] from the need to accommodate mentally disordered servicemen; the Edinburgh Royal Asylum was among the institutions which had been considering accommodating mental defectives, but its offer to receive servicemen resulted in the postponement of the project.[58] But there was one outstanding difference between the two services. While the lunacy service was, in 1914, more than half a century old, the mental deficiency service had been created only months before war broke out. In its case, the war did not disrupt a well-established service, but virtually strangled it at birth.

The process of breakdown began at the most basic level of ascertainment. School boards had the primary responsibility to ascertain defectives, and they were to do so by means of schemes of school medical inspection which, on the eve of the war, had been undertaken in forty-seven districts covering the whole of Scotland apart from Shetland. In 1913, approximately one-third of the school

Table 2:6 Certified Mental Defectives, 1915-19

On 1 Jan.	In Institutions		Private Dwellings	Total
	Adults	Juveniles		
1915	51	156	88	295
1916	305	587	311	1203
1917	340	650	420	1410
1918	356	735	503	1594
1919	352	803	525	1680

Source: Annual Reports of the General Board of Control for Scotland

population were routinely examined annually, and, in addition, a large number of special examinations were carried out in cases where defect was suspected. But the severe strain that the war imposed on the medical services of the country led to the severe curtailment of many of the schemes of inspection, and the complete suspension of others. By July 1919, there was no inspection at all in fifteen areas, and a much reduced service in fifteen others.[59] The discovery and assessment of mental defectives was fundamental to the successful operation of the 1913 Act but (after an initial surge due to the re-certification under the Mental Deficiency Act of those previously dealt with as lunatics), the number of certified mental defectives showed only a modest increase.[60]* Without adequate ascertainment, local authorities could not successfully perform their functions.

Indeed, local authorities were under pressure not to do so. In 1915 the Scottish Office stressed that capital expenditure on mental deficiency should be incurred only in very special circumstances,[61] while the Local Government Board reminded parish councils that the military necessities of the country were the first consideration, and stressed the requirement for economy in every branch of expenditure.[62] Such urging was in fact hardly necessary. While the Treasury grant for mental deficiency had a ceiling of £20,000, in the first year of the Act's operation it was pitched well below that level. Although it was subsequently raised to near the upper limit,[63] it became less adequate as inflation forced the cost of the service upwards. Moreover, the fact that the parliamentary grant amounted to less than half of the cost of maintaining mental defectives[64] meant that, under the proviso of section 26 of the 1913 Act, local authorities were relieved of their obligations to deal with defectives.

*60 Table 2:6

This combination of pressure from the centre and financial restrictions ensured that local initiative in operating the Act was arrested.

The financial stringency of the war years therefore exacerbated the shortage of institutional accommodation which had been apparent even before its outbreak. No new local authority accommodation could be provided. Moreover, some existing accommodation was lost when, in 1915, Grierson Hall Certified Institution was converted into a temporary nurses home for female staff at the Crichton Royal Institution,[65] and Middleton Hall Certified Institution was also required for other purposes.[66] Some new accommodation was provided when St. Charles' Roman Catholic Institution was opened in Glasgow in 1916,[67] but the gravity of the situation obliged the General Board to sanction the admission of defectives into some poorhouses, including those at Barnhill and Craiglockhart. Though the poorhouses were licensed as 'Certified Institutions', there was little attempt to cater for the defectives' needs and, in some instances at least, defectives mingled with the ordinary poorhouse inmates.[68] The 1913 Act had been intended to obviate this necessity and the General Board was obviously uncomfortable about sanctioning such a retrograde step. The lack of any alternative, however, left it little choice.

Nor could the boarding-out system absorb all the defectives who required institutional care. There was a limit to the number of defectives who were suitable for this form of care, and a limit to the number of guardians who were available, particularly when relative prosperity lessened the financial incentive for guardianship. While the placement of defectives in private dwellings relieved the hard-pressed institutional service of some cases, the boarding-out system was not infinitely elastic. After an initial surge because of

recertification under the Mental Deficiency Act, the growth in the number of defectives in private dwellings was steady rather than explosive.[69]*

Neither boarding-out nor poorhouses were therefore any substitute for the provision of new institutional accommodation, and the proper implementation of the 1913 Act was impossible as long as local authorities were unable to provide it. The ascertainment and certification of defectives for whom provision was unavailable seemed futile and as a result an unknown number of defectives were not certified or dealt with. Some received some supervision from voluntary bodies; the Glasgow Association for the Care of Feeble-Minded Children and the Edinburgh Cripple and Invalid Childrens' Aid Society did valuable work in this area and, in 1915, received a grant from the General Board to enable them to continue it.[70] But while these organisations to some extent compensated for the dearth of official activity, their work was inevitably localised. Many defectives were no better off than they had been before the passing of the 1913 Act.

Thus, while patients in mental deficiency institutions suffered similar deprivations to patients in asylums, the effect of the war on the mental deficiency service was if anything more drastic. The combination of economic restrictions, inadequate ascertainment and the scarcity of beds ensured that little could be done to give effect to the provisions of the 1913 Act. Nor could those involved in the mental deficiency service comfort themselves with the belief that positive results accrued despite the disruption, for no-one suggested that the real level of mental deficiency was affected by the war. The service had made a false start. Subsequent events

*69 Table 2:6

would demonstrate whether the time lost would be swiftly made up.

The signing of the armistice was a time for reflection in the mental health service in Scotland. It was a time for looking backwards at the difficulties of asylum administration and the virtual breakdown of the mental deficiency provisions of the 1913 Act, but it was also a time for looking forwards. A few doctors feared that the relaxation of tension would cause some sort of mental reaction.[71] Others, however, were at least cautiously optimistic. It was doubtful whether the decrease - real or apparent - in insanity would continue, but it appeared that some of the other effects of the war might prove to be longer lasting. It had, if nothing else, at least drawn attention to some of the shortcomings of normal provision, and the considerable dissatisfaction with the legal and other arrangements made for the care of the mentally disordered would not easily be dispelled.

PART II

Reform Resumed, 1918-39

Chapter 3 Legal and Administrative Changes

(i) The aftermath of the war

(ii) The reform of local administration: the Local Government (Scotland) Act 1929

(iii) The reform of central administration: Cathcart, Gilmour and the 1939 Act

(i) The aftermath of the war

The cessation of hostilities did not bring an immediate end to the hardships that the lunacy and mental deficiency services had endured for four years. The inflation rate remained high and commodity prices showed no signs of falling. Many supplies were actually more difficult to obtain than they had been during the war. In human terms, too, the cost was still heavy. In the autumn of 1918 an influenza epidemic struck 'a war-exhausted and devitalised world'.[1] Frequently complicated by pneumonia and in Aberdeen compounded by a serious outbreak of baciliary dysentry,[2] influenza was responsible for many fatalities among the patients and staff of mental institutions.[3]

These problems were exacerbated by a wave of staff unrest. The National Asylum Workers' Union, formed in England a decade earlier, extended its operations to Scotland in 1918, and branches were formed in many asylums. It adopted what many considered to be a 'bold revolutionary programme',[4] which included a demand for the introduction of a forty-eight hour week, the state registration of mental nurses and official recognition of the Union by all asylums. It was also determined to end the employment of female nurses for male patients, which had been so extensively utilised during the war. While it claimed to be motivated by the belief that such nursing was 'demoralising and degrading',[5] the N.A.W.U. was almost certainly affected by the widespread concern about dilution, and feared that female nurses would continue to be employed, in preference to men, as a means of saving expense on the wages bill.

The Union's demands inevitably brought it into conflict with

many asylum authorities which considered its demands excessive: they were particularly unwilling to dispense with the female nursing of male patients. At a meeting in August 1918, the medical superintendents of Scots asylums unanimously resolved not to recognise the Union or meet its demands. Royal asylums, which had always resisted any attempt to curtail their freedom of action, were especially hostile; Dr. Robertson, who had previously praised staff for remaining at their posts during the war, now castigated union militants as those who had 'shirked fighting in France or Flanders'.[6] A number of strikes were called at the Edinburgh Royal Asylum in 1919,[7] and an especially acrimonious dispute took place at the Crichton Royal Institution.[8] Nevertheless, as district asylums, and even a few Royal asylums, began to recognise the Union and meet some of its demands, even those which remained adamantly opposed to unionisation were forced to raise wages and improve conditions in order to compete. Unrest began to die down towards the end of 1919, although considerable bitterness remained on both sides.

As staff discontent and the influenza epidemic subsided, the mental health service gradually returned to normality. Male staff levels were, following demobilisation, brought up to strength. Some financial restrictions on the service - including the £20,000 ceiling on the Treasury contribution to the mental deficiency service - were lifted.[9] Institutions which had been converted into military hospitals were, with their improved facilities, returned to civilian use.[10] As wartime and post-war disruption faded, so attention became focused on other, wider issues.

(ii) The reform of local administration: the Local Government (Scotland) Act 1929

One of these issues was the need to reform local administration. The minutiae of local government administration was not a subject of compelling interest to the public or the psychiatric profession. Nor were the needs of the lunacy and mental deficiency services always of paramount importance in the discussion and legislation concerning local administration - to a large extent, the administrative structure of the mental health service would be reformed merely as part of a wider reorganisation. But the problems which the existing system of local administration caused the mental health service did attract attention, and contributed to the climate of change.

Among them were the problems caused by geography and demography. The huge concentration of population and facilities in the central belt and the scattered population and poverty of much of the northern part of the country had long resulted in a very unequal distribution of health resources. But the regional differentials seemed, if anything, to be widening in the post-war years. The rural areas still struggled to provide basic amenities while, in the major urban centres, new and extended facilities were being provided. The expansion of extra-institutional provisions for the treatment of mental disorder was symptomatic of this; by the 1920s, a range of services - observation wards, psychological and psychiatric clinics, nursing homes and child guidance clinics[11] - were springing up in towns and cities, but rural areas could not hope to emulate them. No system of local administration could entirely eliminate regional discrepancies, but a better conceived one, it was felt, could at

least minimise them.

The changing climate of psychiatric opinion also created pressure for the reform of local administration. It was characterised by two outstanding features; an increased stress on the importance of early treatment and a growing belief that the mentally disordered should be treated more like the physically disordered.[12] The existing system of local administration, however, retarded the development of these twin aims. The continued association of the service for the mentally disordered and the Poor Law not only stigmatised the mentally disordered but meant that treatment in the incipient stages of mental disorder was barred to the majority. While parish councils were now represented on district boards, lunacy and mental deficiency functions were still, in most areas, in the hands of three separate local authorities. This made co-ordination difficult, and the continued existence of district boards as separate lunacy and mental deficiency authorities marked out the mentally disordered in a way that was felt to be increasingly unacceptable.

These difficulties were not new. The problems caused by demographic variations, the adverse effect of the association between the service for the mentally disordered and the Poor Law, and the need to encourage early treatment had all received widespread attention before the war. The pressure for the reform of local government in the post-war years, therefore, was, to a large extent, the continuation of a debate which had begun before 1914, but which had been rudely interrupted by the more immediate problems of the war years; questions which had been temporarily shelved became prominent once more in the 1920s.

But the post-war debate was also subtly different, since it

had been affected by the experience of war. The relative prosperity of the war years was, following de-control of the economy, shattered by a slump, and the resultant climate of retrenchment reinforced the need for a system of local government which made the best possible use of the available resources. Above all, perhaps, war had helped to reveal the size and shape of the peacetime problem of mental and physical disorder. The extent to which the innovations of the war-time mental health service affected the course of post-war development is discussed in more detail elsewhere. But in the broadest sense, the war encouraged a new impatience with those factors - including the structure of local administration - which seemed to impede the efforts which were being made to tackle the problem.

The existing pattern of local administration, therefore, seemed increasingly inappropriate to meet the needs of a modern mental health service. It perpetuated regional disparities, and acted as a barrier to the development of a preventive and coherent service. Above all, perhaps, it enshrined a view of the mentally disordered as a singular group which was increasingly at odds with modern psychiatric concepts. Administrative reorganisation could not provide a utopian solution to the problems of the service. But it could at least provide a framework which would encourage, rather than obstruct, the desired developments. The time, it was felt, was now ripe for 'a comprehensive remedial measure which would thoroughly co-ordinate the machinery of local government, lead to greater efficiency and economy, and rectify out-of-date anomalies and restrictions to progress'.[13]

The form that reorganisation should take came under scrutiny. The Committee appointed by the Ministry of Reconstruction to consider

what steps should be taken to secure better co-ordination of public assistance in England and Wales in 1918 laid down a broad policy of reform which it believed would eliminate the overlapping and gaps in existing provision. Its fundamental principle was the concentration, as far as possible, in one local authority in each area of the administration of all expenditure from public funds. The Committee recommended, as a first instalment of the policy, the abolition of the existing poor law authorities and the transfer of their functions to the county and county borough councils. Provision for the mentally disordered, it recommended, should be made by the councils under the Lunacy and Mental Deficiency Acts, suitably extended.[14]

Although the Committee's deliberations were confined to England and Wales, its repercussions were felt in Scotland. Its proposals were referred for consideration to two of the Scottish Consultative Councils established under the terms of the Scottish Board of Health Act 1919 to give advice and assistance to the Board. The Consultative Council on the Highlands and Islands discussed the application of the proposals to its area of interest but concluded that, subject to a compulsory combination of small parishes, parish councils should be retained for all purposes other than the administration of institutions for indoor relief; this, it felt, should be a county council responsibility.[15] The Consultative Council on Local Health Administration, however, considered the proposals from a nationwide perspective and reached a very different conclusion. Although the Council was not unanimous, the Majority were in general agreement with the English Committee, and supported the transfer of the health and poor law functions of Scottish parish councils to county and burgh councils.[16]

About the same time, reorganisation of local administration was also considered by another Consultative Council, that on Medical and Allied Services. It stressed, in its 1920 Report, that medical services had developed in a piecemeal fashion and that State provision, though more or less complete, was not co-ordinated or integrated. The time had come to establish the nation's health service on a broad and comprehensive basis. All the various agencies concerned must be linked up, strengthened and expanded in the interests of bringing a complete and adequate health service within the reach of every member of the community. The keynote of the whole scheme must be co-operation and to that end the Council recommended the unification or fusion of all the local authorities concerned with health.[17]

The pressure to end the patchwork pattern of local administration was strong, but it was several years before definite steps were taken towards reform. A major breakthrough came in 1924 with the appointment of Sir John Gilmour as Secretary for Scotland and subsequently as Secretary of State; both he and his deputy, Walter Elliot, were committed to local government reorganisation.[18] Their convictions were encapsulated in a White Paper on Scottish administration, issued in 1928, which proposed that all the major powers of local government should be vested in county and large burgh councils.[19] The White Paper and the subsequent Bill were vigorously opposed by those who clung to a belief in small-scale government,[20] but their major recommendations bore legislative fruit in the Local Government (Scotland) Act 1929.

It abolished parish councils and district boards of control, and transferred their functions to county councils and the town

councils of large burghs. Ad hoc local education authorities were also swept away, and their functions transferred to county councils and the town councils of the four cities. Thus all the lunacy and mental deficiency and education functions which had previously been discharged by separate, specialist authorities were, in most areas,[21] concentrated in the hands of a single all-purpose local authority which was also responsible for the general health service.[22] These provisions therefore marked a major step forward in the co-ordination of the administrative machinery of the various aspects of the mental health service, and in the co-ordination of the mental and general health services.

The functions of the transferee local authorities would be discharged through a committee system. While the local authority as a whole was ultimately responsible for its functions, the day-to-day administration and supervision of particular aspects of its work would stand referred to committees. It was envisaged that functions relating to the medical treatment of the sick poor would be delegated to the public health committee, while the public assistance committee would discharge poor law and public assistance functions. Education committees would deal with functions concerning that subject.

This division of function was broadly adhered to in the administrative schemes which, under the terms of the Act, local authorities were required to draw up and submit to the Secretary of State. Although some local authorities - including Selkirkshire County Council - established a single committee to discharge both public health and poor law and public assistance functions,[23] most local authorities set up separate public health and public assistance committees, as well as education committees. All three committees

were to play a part in administering the mental health service. Responsibility for the institutional care and treatment of the mentally disordered was delegated to the public health committee. Responsibility for the administration of the Lunacy and Mental Deficiency Acts except insofar as they related to institutional care was normally delegated to the public assistance committee. The Chief Public Assistance Officer (the successor to the Inspector of Poor) was usually entrusted with functions related to the boarding-out of the mentally disordered and with making arrangements for admissions to institutions. Education Committees were given responsibility for the education of mentally defective children.

But there were some areas where the line of demarcation could not easily be drawn, and where there was some question as to the appropriate committee to which functions should be delegated. Responsibility for educable mentally deficient juveniles in institutions was one such borderline case: should it be a health or an education matter? Some local authorities at least considered that it properly fell into the sphere of education, and excepted these children from the general rule that the institutional service was a public health committee concern; Aberdeenshire County Council was among the local authorities which decided that educable children in institutions, as well as those in special schools, should come under the aegis of the education committee.[24] Similar questions arose in respect of the school medical service. Local authorities generally delegated functions relating to the medical inspection and treatment of schoolchildren to the public health committee, but other matters relating to schoolchildren's health - including the question of how individual mentally defective children should best be dealt with -

were normally an education committee responsibility.

But there were considerable local variations. One of the chief differences concerned the establishment of sub-committees, which local authorities could set up to deal with particular aspects of the work of committees. There were persuasive arguments both for and against their establishment. The creation of a sub-committee could ensure that the interests of a particular group were not swamped or overlooked in the wider business of the committee or the council. Co-option to a sub-committee was also a means by which those with special experience or expertise could become involved with the work. But the establishment of sub-committees also carried dangers; it could lead to the fragmentation and compartmentalisation of the committee's functions.

However, the General Board was convinced that local authorities had to establish lunacy and mental deficiency sub-committees if the interests of the mentally disordered were to receive the attention which they deserved; a sub-committee of the public health committee, with representation from the public assistance committee and co-opted members, was, it felt, the ideal arrangement.[25] Some local authorities did provide for their establishment: Aberdeenshire County Council's administrative scheme, for example, established a 'Mental Diseases Sub-Committee' to which was delegated all the lunacy and mental deficiency functions which devolved on the Council's Public Health Committee.[26] Some other local authorities, however, despite making general provision for sub-committees and notwithstanding the Board's strong advocacy of them, did not make specific provision for setting up mental health sub-committees.[27] The Secretary of State did not use his power of sanction to compel them to do so.

However, the Act did more than transfer existing powers from ad hoc to 'omnibus' local authorities. It also gave the major local authorities an important new power which enabled them to remove from the sphere of the Poor Law all those services which could be provided by alternative means. Section 14 (4) empowered local authorities to declare (in their administrative schemes) that any assistance which could be granted either under the Poor Laws or under other statutory powers would, in future, be provided exclusively under enactments other than the Poor Laws. The clause was 'the basis of future developments in the direction of the breakup of the Poor Law'.'[28]

The maintenance and treatment of mental defectives - but not, apparently, of lunatics[29] - was among the services which could be provided under the Poor Law or otherwise. But while some services - including the maternity and child welfare services, and provision for the blind - were almost invariably removed from the Poor Law, some local authorities seemed reluctant to use their power to dissociate the mental deficiency service from the Poor Law. The General Board continually urged them to do so, stressing that the association between the Poor Law and mental deficiency was 'a hindrance to progress'.[30] In some cases its representations were successful; Selkirkshire County Council, for example, did not originally include mental defectives within the ranks of those who would be removed from the Poor Law, but subsequently declared that assistance for them would be provided exclusively under the Mental Deficiency Acts.[31] A few local authorities remained intransigent. Nevertheless, the majority of administrative schemes did provide for the dissociation from the Poor Law of the maintenance and treatment of mental defectives.[32]

The Act therefore marked a major step towards the 'depauperisation' of the mentally disordered. Parish councils and district boards were no longer responsible for making provision for the mentally disordered poor; liability for their maintenance became a charge upon the county or town council rates, while responsibility for making provision for their institutional care and treatment was delegated to the public health committees of the major local authorities. Even where assistance was given by the public assistance committee it would, in many cases, be under provisions other than the Poor Law. The Act did not mark the end of 'pauper lunacy'; it lived on under the terms of the unamended Lunacy Acts. But it had irrevocably weakened the association between the service for the mentally disordered and the Poor Law.

The 1929 Act was generally regarded as 'the major Scottish legislative achievement of the 1920s'.[33] Its future impact on the mental health service, however, was problematical. The fact that, in general, three different committees had major functions in respect of the mentally disordered meant that active co-operation between them was essential if the fragmentation which had previously plagued the service was to be avoided. The transfer of functions from specialist to omnibus local authorities also carried the danger that the mentally disordered would be overlooked, particularly where there was no mental health sub-committee. But the Act also held out the promise of positive changes. The new local authorities were larger and commanded greater financial resources than their predecessors. It therefore seemed likely that some of the grosser regional inequalities might be ironed out, and that the new local authorities might be able to do more to provide preventive and promotive services.

Above all, the Act seemed to offer a new opportunity for the development of a more integrated mental health service, and one which was more closely associated with the general health service. The extent to which these aspirations were fulfilled is discussed in the following chapters. But there was some unfinished administrative business to attend to first.

(iii) The reform of central administration: Cathcart, Gilmour and the 1939 Act

The unification of local administration highlighted the apparent irrationality of the continued fragmentation of central administration. In the decade following the war, some steps in the direction of unification were taken. Three bodies - the Local Government Board for Scotland, the Scottish Insurance Commissioners and the Highlands and Islands (Medical Services) Board - were, in 1919, absorbed into the new Scottish Board of Health. The problems of the low status of the office of the Secretary for Scotland, who was responsible for the general oversight of some of the central authorities, and of his lack of control over their operations, were also addressed. In 1926, the Secretary for Scotland became one of His Majesty's Principal Secretaries of State, and the first occupant of the new office of Secretary of State - Sir John Gilmour - was responsible for the Re-organisation of Offices (Scotland) Act 1928. It established the Department of Health for Scotland as the successor to the Scottish Board of Health and although it retained its own statutory existence, the new Department acted under the control and direction of the Secretary of State. This attempt to combine ministerial responsibility with some measure of Departmental

independence was not wholly successful,[34] but, by the late 1920s, at least some of the more important health functions were concentrated in the hands of a single Department over which the Secretary of State had increased control.

However, functions relating to lunacy and mental deficiency were still in the hands of a variety of central bodies, and in some cases closely related functions were divided between two or more Departments. Thus, the Department of Health supervised the medical inspection of schoolchildren, but the Scottish Education Department was responsible for school health services generally. Special schools and classes for juvenile mental defectives were under the aegis of the S.E.D., but certified institutions, which also accommodated some educable defectives, were the responsibility of the General Board. The Prisons Department, too, had responsibilities relating to lunacy and mental deficiency; it administered the Criminal Lunatic Department at Perth Prison, and, in conjunction with the General Board, the State Institution for Defectives. The Scottish Office was also involved in the mental health service. It was concerned with the lunacy and mental deficiency functions which were vested in the Secretary of State (including the approval of contracts and estimates for new buildings). It also dealt with letters to the Minister from or about detained lunatics, and considered proposals which required the approval of the Minister or the Treasury. The Scottish Office was also intimately involved in questions relating to new legislation. In effect it acted as the General Board's superior Department, although when the policy had been determined, its execution was left very much in the Board's hands.

But the most damaging division of responsibility undoubtedly

was that between the General Board and the Department of Health. It bisected the health service, since the Board was responsible for the mental health service and the Department was responsible for all general health resources. Moreover, the mental health service was itself administratively divided; while the Board dealt with certified lunacy and mental deficiency, all other nervous and mental conditions were legally within the Department's scope.[35] The central administrative machinery of the health service, therefore, like that of local administration before 1929, had not kept pace with developments which were taking place elsewhere in the service and the continued separation of mental from physical health, and of certified from non-certified conditions, seemed increasingly artificial and anachronistic.

The aspirations of those who wanted a stock-taking of the nation's health policy were fulfilled when, in June 1933, the Committee on Scottish Health Services was appointed under the chairmanship of E.P. Cathcart, Professor of Physiology at Glasgow University. It was given a wide-ranging remit to review existing health services in the light of modern conditions and knowledge, and to make recommendations on any changes in policy or organisation that might be considered necessary for the promotion of efficiency and economy. The Cathcart Committee's 1936 Report was 'the first full and comprehensive study of all the services which have a bearing on the health of the Scottish people',[36] and its main conclusion was that 'many adjustments and some substantial extensions' of existing provision were required'.[37]

The Committee's recommendations on the future administration of the mental health service sprang from two major premises. The

first was that there was an outstanding need for a co-ordinated attack on nervous and mental disorders, especially in the early, pre-certification stage. The second derived from the Committee's view that mental and physical disorder were intimately related. Although it had heard conflicting evidence on the relative importance of organic factors in the causation of mental disorder,[38] the Committee concluded that there must be the closest possible association between measures to improve mental and physical health, and stressed that the treatment of the mentally disordered should approximate as closely as possible to that of the physically disordered.[39]

These principles were reflected in the Cathcart Committee's proposals. It was convinced that reform of the central administrative machinery of the mental health service was essential for the realisation of its twin aims. As long as responsibility for the general and mental health services rested in different hands, the formation of a united front to tackle mental disorder, and the formation of a cohesive health service, seemed unattainable. The continuation of the existing relationship - or lack of it - between the General Board and the Department of Health was, from the Committee's standpoint, untenable.

The Committee discussed two main courses of action. The first option - the extension of the General Board's powers in order to allow it to deal with uncertified patients - was rejected on the grounds that it would carry the Board too far into the proper sphere of the Department and result in duplication and overlapping. In line with its conception of a strong Department of Health, equipped to give a lead and guidance throughout , it instead recommended that responsibility for the administration of the mental health service be

transferred from the Board to the Department. The Board's liberty-of-the-subject functions should be transferred to the Sheriff. The Committee in fact recommended the abolition of the General Board.[40]

The Committee regarded this as both the continuance of a logical process of the unification of central and local administration, and as a means of encouraging the development of a more effective and integrated service. But it also had symbolic significance. It reflected the view that the mentally disordered should no longer be regarded as a class apart. While the loss of liberty that certification entailed meant that some authority should be charged with protecting the mentally disordered, the Committee did not believe that those functions, or the administration of the service, required a separate, specialist body; indeed, it strongly suggested that the existing legal basis of the service should itself be included in a complete revision and consolidation of the Lunacy Laws.[41] As a first step towards what it hoped might be more fundamental change, however, it recommended the unification of the central administration of the health service.

The Report's major recommendations regarding the mental health service received a mixed reception. Local authorities, which found the cleavage at the centre irksome, were generally in favour of them, as were Medical Officers of Health. The Scottish Division of the Medico-Psychological Association (the professional organisation for pscyhiatrists) also supported the abolition of the General Board, but urged the establishment of a Department of Mental Health, 'complementary to and conjoined with' the Department of Health. The General Board itself, however, was not enthusiastic about its proposed abolition, since although it acknowledged that a closer

relationship between it and the Department was desirable, it was convinced that liberty-of-the-subject work was best done by an authority consisting of legal and medical members.[42] The reaction to the Cathcart Report meant that no immediate steps were taken to implement it.

The question of the General Board's abolition, however, came under further scrutiny from the Committee on Scottish Administration appointed, in 1936, to enquire into the position and duties of Scottish administrative departments, including the Departments of Health and Education. Its Chairman, significantly, was Sir John Gilmour who, at the time of the reorganisation of offices in the late 1920s, had made it clear that his ultimate aim was to centralise under one roof in Edinburgh all the Departments concerned with Scottish business.[43] Now he had the opportunity to press his case, and the Committee's 1937 Report reflected his conviction. The lack of co-ordination, it recommended, could best be overcome by abolishing the statutory Departments and transferring their functions to the Secretary of State. These functions would be discharged through four Departments of equal status, including Health, Education and a new Home Department which would deal with the work presently dealt with by the Scottish Office.[44]

The Gilmour Committee also discussed the General Board's position, but although it endorsed the concept that mental and physical disorder should be treated, as far as possible, alike, it did not share the Cathcart Committee's view that this required the abolition of the Board. The Gilmour Committee felt that there were special reasons for the Board's retention; the interests of the mentally disordered required the existence of a body with independent

functions and free from Parliamentary pressure, and the Board enjoyed public confidence. Its combination of legal and medical members was particularly appropriate for dealing with liberty-of-the-subject matters - like discharges from institutions - which involved an element of medical judgement. The Gilmour Committee thus suggested that the Board should retain its existing functions, but proposed constitutional changes which would forge a closer relationship between the Board and the other Departments. An officer of the Department of Health should become Chairman of the Board, and the Board's staff should come to be regarded as part of the staff of the Department. The Board should be strengthened by the appointment of a paid legal member and, finally, an officer of the S.E.D. should be appointed to it.[45]

In the late 1930s, then, there was general agreement that the structure and relationships of the Scottish Departments were unsatisfactory, and that some form of reorganisation which, inter alia, would provide for closer contact between the central mental and general health authorities was needed. But there was no clear consensus as to how this should be achieved, and reform of any sort seemed fraught with danger. The implementation of the Cathcart proposals might mean that fine distinctions would have to be made between administrative and quasi-judicial functions in every-day work,[46] and without power to intervene in the institutional service, the liberty-of-the-subject authority could find it difficult to perform its duty of protecting the interests of the individual. But if, as Gilmour recommended, the Board retained its existing functions, the development of an integrated service might be more difficult. Dr. Mackintosh, Chief Medical Officer of the Department of Health,

favoured another alternative; the transfer of the Board's administrative functions to the Department, but the Board's retention as a liberty-of-the-subject authority.[47] This, however, carried the same dangers as the Cathcart proposals, and it was, further, doubtful whether liberty-of-the-subject functions alone would warrant the Board's continuance as a separate - or quasi-separate - entity.

These points were considered when the future of the General Board was discussed in consultation with the Heads of Departments in 1937 and 1938. The option of abolishing the Board, or even of hiving off some of its functions, was rejected; there was general agreement with the Under Secretary of State's view that the Board's administrative and quasi-judicial functions were 'so inextricably bound up together' that a division of function would lead to inefficiency and friction.[48] But there was also a consensus that things could not remain as they were. The solution offered by the Gilmour Committee seemed most likely to provide the benefits of closer integration without the problems of unscrambling closely connected functions. It was determined that the implementation of the Report's recommendations in respect of the Board would take place as part of a wider restructuring of Scottish administration.

The resultant Reorganisation of Offices (Scotland) Act 1939 was described by John Colville, then Secretary of State, as 'the most comprehensive reform of Government in Scotland since 1885'.[49] The Department of Health for Scotland and the Scottish Education Department ceased to have a separate status of their own; their functions, and those of the Prisons Department, were transferred to and vested in the Secretary of State. The Act also enacted the first major constitutional change in the General Board of Control since it had

been established - as the General Board of Commissioners in Lunacy - in 1857. The Chairman of the Board would in future be an officer - of Assistant Secretary rank - of the Department of Health and an education member was appointed to the Board to co-ordinate its work with that of the S.E.D. in matters of mutual concern, like mentally defective children. The Chairman, and all the Commissioners, were to be salaried.

The 1939 Act did not go as far as some members of the Gilmour Committee would have liked.[50] The Committee, and the Act, rejected the common staffing of the Departments which, by allowing for easy interchange of staff, might have encouraged a greater community of effort. As it was, fierce Departmental loyalties and the 'irritatingly individual' habits of the Departments did not disappear overnight.[51] Nevertheless, the vesting of the functions of the Departments in the Secretary of State, and the concentration of the Departments in St Andrew's House, did provide a more flexible and unified administrative structure, which held out the promise of closer co-ordination between the various aspects of the mental health service and between the mental and general health services. The 1939 Act, like the 1929 Act, reduced the administrative isolation of the lunacy and mental deficiency service.

The General Board, however, though brought into closer contact with the Department of Health and the S.E.D., survived the reorganisation. Its continuation was undoubtedly partly 'a recognition of its good name'.[52] But it also mirrored the perception that the lunacy and mental deficiency service remained a special case. The 1939 Act embodied not only a desire to administratively reflect and encourage the close association between mental and physical disorder,

but also the conviction that the mentally disordered were different. It seemed likely that they would continue to be so regarded as long as compulsion and detention remained the legal basis of the service.

The recognition that administrative reorganisation alone could not break down the barriers between the mental and general health services was apparent in the late 1930s, and it seemed that some sort of reform of the legal basis of the service might be imminent. A few months after the Gilmour Committee reported the first step towards meeting the Cathcart Committee's demand for revision and consolidation of the legal framework of the service was taken. In February 1938 a Departmental Committee on the Scottish Lunacy and Mental Deficiency Laws was appointed, under the Chairmanship of the judge Lord (Albert) Russell to conduct a wide-ranging investigation into the legal arrangements made for the treatment of mental disorder. It had made considerable progress by the time the outbreak of World War Two interrupted its deliberations and resulted in its temporary suspension.[53]

The reform of central administration which took place in 1939 would, like the Russell Report, make its impact in the years after 1939; although the 1939 Act was to play a significant role in determining the shape of the wartime and post-war health service, it came too late to affect the administration of the mental health service in the inter-war years. Nevertheless, the attitudes and perceptions which informed it, and which had influenced the reform of local government a decade earlier, were reflected in many of the other developments which took place in the inter-war period. The new emphasis on the need to attack mental disorder in its incipient stages and to bridge the gap between the treatment of mental and physical disorders was also apparent at the grassroots level, and its consequences are discussed in the following chapters.

Chapter 4 Provisions for Juveniles

(i) Intelligence tests and ascertainment

(ii) The educable, the ineducable and after-care

(iii) The Scottish Association for Mental Welfare

(iv) The child guidance movement

(i) Ascertainment and intelligence tests

The education service emerged from the disruption of war to face administrative re-organisation. Under the terms of the Education (Scotland) Act 1918 parish schoolboards and county committees for secondary education were replaced by comprehensive education authorities in each of the counties and four cities. However, the first duty of the re-organised L.E.A.s in respect of juvenile mental defectives remained their ascertainment; the assessment and if necessary the certification of cases of defect which came to light at routine school medical inspections, or which were reported for investigation by a teacher, doctor, the courts or other agencies. The development of new methods of diagnosis and categorisation appeared to offer new opportunities for more accurate ascertainment.

Francis Galton, the English eugenist and scientist, is generally regarded as the founding father of the specialism of individual psychology - which concerned itself with the nature and distribution of differences between persons in respect of intelligence and personality - that emerged at the turn of the century. His search for support for the tenets of eugenics led Galton into biological, statistical and psychological research and into the possibilities of testing and measuring mental differences. But the first modern schemes for measuring intelligence came from the Frenchmen Binet and Simon. Their tests, first published in 1905, aimed to test a range of abilities including vocabulary, memory, spatial perception and reasoning and provided a means of illustrating the results through the device of the 'mental age', which could be compared to the chronological age to assess the degree of retardation.[1] Shortly afterwards the German psychologist Stern used the mental age to produce the

device of the intelligence quotient or I.Q., a figure which provided a means of describing a child's abilities and a method of comparing them with those of another.[2] These new tools had two obvious areas of application: the identification of 'gifted' children and the identification of mental defectives.

Scotland provided fertile ground for the growth of mental testing. The English psychologist Cyril Burt argued that the early Scottish interest in phrenology meant that a systematic interest in individual psychology first appeared in Scotland.[3] Scottish universities appeared to be 'more friendly' to psychology than English ones;[4] in Edinburgh, for example, the Combe Lectureship in Psychology was established in 1906 and practical experience was provided in the psychological laboratory which was opened in the City at about the same time.[5] Above all there was in Scotland a particularly close relationship between psychology and teacher training. Regulations introduced in 1906 stipulated that all teachers in training were given a course in psychology and when Moray House College opened in 1912 it included a 'pedagogical laboratory' which was, in effect, the first British laboratory for educational psychology.[6] Towards the end of World War One, a higher degree in education and psychology - that of Bachelor of Education - was established at three of the four universities,[7] and the holders of this degree played a large part in disseminating knowledge about the psychology of individual differences.

Another major step towards widespread acceptance of psychological testing was taken in 1923 when David Kennedy Fraser was appointed psychological adviser to Glasgow Education Authority, the first such appointment made in Scotland. The major part of his work was the assessment of allegedly mentally defective children, and he

did pioneering work in the application of mental tests as a diagnostic tool. Equally important, however, was Kennedy Fraser's role as an educator. In his other capacity as a lecturer at Jordanhill Training College, he trained, for all Scotland, teachers of the mentally defective and as a natural consequence of his own interest in the subject the course contained a substantial element on investigation by testing.[8] At the same time Godfrey Thomson, who combined the Principalship of Moray House College with the Chair of Education at Edinburgh University, was both developing mental tests and conducting a consulting service on mental testing.[9] In both cities, therefore, tests were finding practical application and information about them was being circulated.

Testing therefore began to play a significant role in ascertainment in the mid-1920s, and the momentum was continued and accelerated in the 1930s. Tests were used in a wide variety of settings, including the educational and psychological clinics in training colleges and universities, psychiatric and child guidance clinics, and ordinary and special schools, and a multiplicity of different tests were developed. Educational attainment tests were used to screen children. Edinburgh Education Committee, for example, in the mid-1930s recommended that Ballard's One Minute Tests in reading and arithmetic should be applied to children leaving the infants' department, and that those who appeared to require further investigation should then be individually tested.[10] The most popular of these individual tests - the Stanford-Binet Test (Terman's Revision) - was, it was estimated, applied to at least a thousand cases a year by the late 1930s.[11] Group tests were also used; indeed, the Scottish Council for Research in Education in 1932 employed group tests on a

massive scale, and individual tests on a much smaller scale, in its ambitious survey of the intelligence of Scottish schoolchildren.[12]

The results of testing therefore became an important determinant for classification as a mental defective, and for placement in, or exclusion from, a special school. The S.E.D. stressed the need for a balanced approach ; tests, it urged, must be applied with skill and tact, and their results should not be adhered to 'slavishly'.[13] But the Department itself regarded I.Q. 50 as the approximate boundary betwen the educable and ineducable defective.[14] Such reservations as there were primarily concerned the proper application and use of tests rather than the concepts which underlay them. The concept that test results were valuable predictors of future performance would subsequently become controversial but in the 1930s it was generally accepted that tests should form an integral part of classification.

The increasing use of tests which appeared to provide for more accurate and sophisticated diagnosis and to reduce the element of subjectivity inherent in ascertainment might have been expected to produce virtually complete ascertainment. The evidence suggests, however, that this was not the case; as late as 1936, the (Cathcart) Committee on Scottish Health Services found that ascertainment was 'very partial' and was only 'reasonably complete' in a few areas.[15] What were the reasons for this?

The attitudes of all those involved in ascertainment, and particularly of school medical officers, parents and teachers, was particularly significant. The ascertainment figures to a large extent reflected the standards adopted by school medical officers, and the thoroughness of their investigations. Lack of experience of mental deficiency may have been a problem,[16] but the S.E.D. was convinced

that a more serious difficulty was the fear in some doctors' minds that notification of defect did irreparable harm to a child. The Department believed that this concern about the consequences of labelling sprang from confusion between notification of defect (which, in many cases, could be dealt with without judicial process) and certification as a lunatic, with all its attendant connotations of loss of liberty and permanent detention; for this reason, it believed, some doctors were unwilling to report all but the severest cases of defect.[17]

Parents and teachers in some cases shared the doctors' reluctance. Parental consent was, as already described, generally a prerequisite for dealing with a juvenile defective and although it is difficult to evaluate the scale of the problem the S.E.D. was concerned by what it acknowledged was the understandable disinclination of parents to have their offspring classified as defective. Some teachers, too, from similar sympathetic motives, were unwilling to co-operate in ascertainment.[18] The increasing use of mental tests during the 1930s seemed to be breaking down the resistance of parents, teachers and doctors,[19] but it was a slow process. Without some fundamental change in the public perception of mental deficiency it seemed likely that non-co-operation would continue to be a barrier to complete ascertainment.

Legislation - or the lack of it - also played a part. Both the Scottish and English Mental Deficiency Acts 1913 defined mental deficiency as a condition which existed from birth or from an early age, and those who became defective later in life did not come under their provisions. But the previously narrow definition was, in England, broadened by the Mental Deficiency Act 1927, which eliminated

the 'birth or an early age' stipulation and brought within the scope of the service all cases, whether due to inherent causes or otherwise, which arose before the age of eighteen.[20] In Scotland, however, no such change was made. Older children who became impaired as a result of injury, or diseases of the brain like encephalitis or meningitis, remained outside the boundary of the service, and L.E.A.s were not required to ascertain them.

At the opposite end of the juvenile age-range, there was no obligation to ascertain pre-school-age defectives.. Despite the 1913 Act's definition of mental deficiency, and notwithstanding the wide-spread realisation of the vital importance of the earliest possible detection and treatment, much valuable time was wasted during the years when, perhaps, help was most urgently needed and might have been most effective. The unmet needs of the under-fives were sometimes recognised; Dr. McAlister, Superintendent of Bangour Asylum in the 1930s, urged (unsuccessfully) that special provision should be made for some of the most severely defective cases, and a few were admitted to ordinary nurseries.[21] But there was no general provision for defectives in the youngest age-group, and no formal ascertainment of them.

These factors, however, could not fully explain why the incidence of deficiency appeared to be much lower in rural areas than in urban areas.[22] While regional variation in the incidence of mental defect may have been a contributory cause, it did not, by itself, appear to provide a credible explanation for the disparity. The root cause of the variation, and also of the inadequacy of ascertainment in general, lay instead in the provision that was available for juvenile defectives in special schools and

classes, day centres and institutions.

(ii) The educable, the ineducable and after-care

Substantial progress was made in special education for mental defectives during the inter-war period. The staffing of the service was the first of two main areas where this improvement was most evident. Until the early 1920s special schools were staffed by teachers with no special training in mental deficiency. However, a training opportunity was provided when in 1923 the Jordanhill course, mentioned earlier, was started. It experienced some difficulty in attracting students: in fact, in an attempt to stimulate recruitment, the length of the course was reduced from six to three months in the early 1930s.[23] But while mental deficiency teaching might not have had widespread appeal, at least some teachers were specially trained for their work; 199 teachers completed the Jordanhill course in the period 1927-37.[24]

There was,secondly,a considerable expansion in the amount of provision available. The number of mental defectives attending special schools, and special classes in ordinary schools, more than doubled in the inter-war period, rising from 2,290 in 1919 to 4,800 in 1938, when there were nine day schools for mental defectives, nineteen day schools accommodating both mentally defective children and physically defective children and forty-three ordinary schools with special classes (not all of them for mental defectives).[25] More institutions for juveniles were also provided in the period, among them a second Roman Catholic institution and local authority institutions in Kilmarnock, Lesmahagow and Port Glasgow, as well as Gogarburn Institution in Edinburgh.[26]

However, the progress which was made was very uneven, and there was a stark contrast between the provisions available in urban and rural areas. The percentage of children in special schools in the burghs, it was estimated in 1922, was approximately fifteen times greater than it was in the counties.[27] Little had changed almost a decade later when, in 1931, the S.E.D. acknowledged the 'notorious' lack of special schools in rural areas.[28] Even in the late 1930s, approximately one-third of L.E.A.s had no local provision for mentally defective children.[29] The sparse and scattered population of much of the country outside the central belt meant that many areas found it difficult to gather enough pupils together to form a special school, or even a special class: residential special schools would have alleviated the problem, but they were confined to physically defective pupils.[30] Nor did mental deficiency institutions provide an answer to the problems of rural areas since, despite the new accommodation, places remained in short supply.

In many areas, then, there was little opportunity for mental defectives to obtain special education, and many continued to attend ordinary schools where neither the curriculum nor the teachers were equipped to cope with their needs. The Education (Scotland) Act 1936 provided some grounds for optimism: it amended the 1906 Education Act so as to make it a duty, rather than a permissive power, for education authorities to provide special education, and it amended the 1913 Mental Deficiency Act so as to make this obligation irrespective of parental capacity to pay. But although it strengthened the authorities' duties and helped to focus more attention on the inadequacy of existing provision, the 1936 Act came too late to make any significant difference in the short term to the unequal distribution of provision.

Better provision was also urgently required for severely defective 'ineducable' children who, under the terms of the 1913 Act, were excluded from the school system. The provisions that were made for them was one of the most unsatisfactory aspects of the 1913 Act; since they were ascertained by the L.E.A., but were the responsibility of the parish council, the care of ineducables depended upon one local authority notifying another at the appropriate time; and parish councils were, in any case, ill-equipped to deal with defective children. However, the 1929 Local Government Act made co-ordination easier since, under the new structures, the same local authority was responsible for both the educable and the ineducable (in most areas);[31] in fact in some areas, including Edinburgh, responsibility for training ineducables and educating educables was in the hands of the same (education) committee.[32] There was less cohesion in large burghs, where responsibility for the ineducable and the educable remained divided between local authorities,[33] but in general the new administrative arrangements were more satisfactory than the previous ones had been.

But the new local authorities faced similar problems in actually dealing with ineducables. The only special provision (apart from boarding out) which the statutes authorised for them was removal to an institution. However, as already mentioned, the demand for mental deficiency beds outstripped supply. The lack of an alternative therefore meant that some ineducables were sent to the special schools from which they were in theory excluded.[34] This was an unsatisfactory expedient; special schools were not intended or equipped to deal with severely defective children. Ineducables also encroached upon the number of school places available for educable children and, the S.E.D.

believed, hampered the progress and damaged the prestige of special education.[35]

There was therefore an outstanding need for some sort of provision for ineducable children who could not obtain - or did not require - institutional care. In many cities and towns, day centres were provided by voluntary effort[36] and in Edinburgh the Education Committee ran an occupation centre in the 1930s.[37] But while English local authorities were in 1927 enabled to establish training centres,[38] their Scottish counterparts did not have specific powers to do so. The General Board and the S.E.D. in the 1930s advocated that statutory provision for the establishment of training centres should be extended to Scotland, but without success.[39] Ineducable juveniles remained the second-class citizens of the mental deficiency service. Many received no training and were, as the General Board acknowledged in 1931, no better off than they had been before 1913, and may even have been in a more disadvantaged position.[40]

The arrangements made for the after-care of defectives over the age of sixteen were similarly inadequate. The 1913 Act did make some provision for after-care; section 3(2) required the L.E.A. to intimate to the parish council and the General Board those whose discharge from special schools, institutions or guardianship was imminent and who, in the L.E.A.'s opinion, required further care in an institution or under guardianship. But there were difficulties. The after-care of educables, like the care of ineducables, before 1929 depended upon one authority notifying another at the appropriate time. The L.E.A.s' notification obligation was also a limited one; no provision was made for the after-care of those who did not require institutional care or guardianship but who might have benefitted from some less formal

supervision.

Above all, however, after-care was effectively confined to those for whom special provision had been made by the L.E.A. Parish councils were, until 1929, responsible for the ascertainment of older defectives but in general they lacked the means to undertake it. Even if it did come across an unascertained older defective, the council could not deal with the case unless the defective fell into one of the categories of nuisance or danger specified by the 1913 Act. In reality, then, parish councils normally dealt only with defectives intimated to it by the L.E.A.[41] If that body had not ascertained the case then, obviously, it could not notify it to the council. But even if the L.E.A. was aware of the case, it was not obliged to notify it to the council unless the child had been in a special school or institution or under guardianship. Defective children who left ordinary schools at fourteen were therefore excluded from after-care. They were, in practice, prevented from receiving care after the age of sixteen because they had not received it before sixteen. It was, as the S.E.D. remarked in 1931, a 'ridiculous' situation.[42]

Once again, the re-organisation of 1929 largely eliminated the administrative difficulties, since the necessity for a sixteen-year-old educable defective to be transferred from one authority to another, and thus the requirement for notification, was abolished in most areas.[43] The other difficulties, however, remained. Despite pressure from the General Board and the S.E.D., after-care was not extended to the defective leaving the ordinary school.[44] Nor were local authorities empowered to provide additional facilities for after-care and they had little to offer the school leaver except an institutional bed - if one could be found - or guardianship. This lack of support for

those living in the community was particularly unfortunate when the mass unemployment of the 1930s reduced the defectives' chances of obtaining a job. So far as the statutory sector was concerned, many adolescent defectives were cast adrift to sink or swim.

It was, in fact, the amount of provision which was available which was the primary cause of variations in ascertainment. While the other factors earlier described played a part, the existence or non-existence of special schools and classes, institutions and day centres was the most important influence on ascertainment. The S.E.D. recognised the relationship, and urged that ascertainment should be thoroughly undertaken even where provision was not available. Nevertheless, as the Department recognised, local authorities which had no provisions remained reluctant to take action.[45]

(iii) The Scottish Association for Mental Welfare

The general inadequacy of statutory provision therefore provided an opportunity for voluntary effort. It played a proportionately greater role in the mental deficiency service than in the lunacy service during the inter-war years; while the latter had been relatively complete for some time, the mental deficiency service, which was still in its infancy in 1918, offered more scope for the volunteer. Further, those of a eugenist persuasion were interested in voluntary work with mental defectives from the standpoint of providing the control which the statutory sector seemed unable to supply. Mentally defective children in particular were also, perhaps, a more appealing object of benevolent activity than were adult lunatics.

A number of voluntary organisations had, by 1918, been active in the field for some years. There were various English-based

societies, such as the Central Association for the Care of the Mentally Defective. There were also local bodies, some of which - like the Glasgow Association for the Care of Feeble-Minded Children - were specifically concerned with mental defectives, and others - such as the Councils of Social Service - which dealt with the mentally defective as part of their wider work with the disabled and disadvantaged. But it was not until the 1920s that the first nationwide Scottish voluntary society for the mentally disordered was founded. The Scottish Association of Care Committees grew out of a local care committee formed in Paisley shortly after the end of World War One, and was founded with the active support of the General Board of Control. It originally included physically disabled children in its scope, and continued to take an interest in them; but at an early stage it apparently decided to concentrate its attention primarily upon mental defectives. In the early 1920s the S.A.C.C. became the Scottish Association for Mental Welfare.[46]

The new Association was intended to be broadly based; while S.A.M.W. was particularly anxious to include representatives of administrative and social bodies concerned with mental defectives, membership was open to all who were interested in its work. The combination of propaganda and practical activity which this work would entail, and which would characterise the Association for many years, was apparent from its foundation. S.A.M.W. was primarily concerned with groups which the statutory sector tended to neglect; ineducable children and adolescent and adult defectives living at home. It wanted to arouse interest in their problems, and in the subject of mental defect in general. It aimed to make domiciliary visitation more effective by arranging for the instruction of those who undertook

it, and was prepared to offer advice and assistance in individual cases of mental defect. But it was envisaged that most of the directly practical work would be done by local groups which the Association was committed to fostering.[47]

The encouragement of the grassroots endeavours of local care committees was at the core of the Association's work. It aimed to provide an 'umbrella' for the co-ordination of their activities, and provided a model constitution and rules for them. The (somewhat sparse) surviving records of S.A.M.W.-affiliates in the inter-war period indicate that local groups did, as the parent Association advised, try to involve a broad cross-section of statutory and voluntary organisations in their work, and gave the visitation of defectives a high priority.[48] Urged on by S.A.M.W., some L.C.C.s opened day centres for defectives. 'Occupation centres' were intended for the younger and more severely handicapped; they concentrated on the development of basic skills and provided a variety of educative and recreational activities. 'Employment centres' catered for older defectives, who were often ex-special school pupils, and were more practically and commercially orientated. They provided instruction in handwork and crafts; those attending were generally paid for the work they produced, and the finished articles were sold.

A network of centres had been established by the early 1930s. Some local groups - including those in Paisley, Clydebank and Kirkcaldy - ran both occupation and employment centres. One or other of these centres, and other facilities like social clubs and handicraft classes were conducted by many other of the twenty-one affiliated local groups which had been established by the end of S.A.M.W.'s first decade.[49] In rural areas, geography and demography

made the establishment of centres more difficult, and the provisions were largely confined to the cities and larger towns. There, the centres provided training for many ineducable children who would otherwise have received none and, particularly during the depression of the 1930s, they also offered the only paid 'employment' available to many older defectives.

The extent to which S.A.M.W. fulfilled its aims, however, was largely dependent upon funding. From its inception the Association received miscellaneous subscriptions and donations from a variety of statutory bodies, including parish councils, district boards of control and local education authorities, as well as from non-statutory bodies and private individuals, but its most important source of income for most of the 1920s was the annual grant from the General Board. Its first offering - of £20 - was given in November 1921, and its contribution escalated in the years which followed: in 1928-29 it totalled £600 and formed three-quarters of S.A.M.W.'s income. But when this grant became, under the terms of the Local Government (Scotland) Act 1929, the responsibility of the major local authorities, the Association faced a financial crisis; it had been apprehensive about the change and its fears were borne out when the grant fell dramatically to less than £250 in the first year (1930-31) of the Act's operation. But as the disruption of re-organisation died down, and after the General Board reminded local authorities of the valuable work the Association performed, the grant was subsequently raised, and it remained at approximately £750 for the rest of the decade.[50]

Local care committees were also much concerned with financial matters. They had three main sources of income. The first - grants from the parent Association - varied from one group to another[51] and

many groups were forced.to rely heavily on funding from other sources. Some received donations and subscriptions from local statutory bodies and from various other organisations in their areas: the police force, for example, was for some reason a particularly enthusiastic supporter of the Dumbarton group during the 1930s.[52] The third source of funding for local groups was their own efforts and the usual fund-raising methods - like flag days, fetes and sales of work - were used to raise revenue.[53]

Nevertheless, the financial difficulties which S.A.M.W. experienced, particularly during the early 1930s, limited its development. It constrained the work which individual groups were able to undertake, hampering, for example, Dumbarton's efforts to open an occupation centre.[54] But it also frustrated the expansion of the Association as a whole. While active local care committees had, by the mid-1930s, been established in many urban areas there was, surprisingly perhaps, no local group in the Aberdeen area.[55] Financial constraints were one of the major reasons why the Association's original objective of establishing a local care committee in the area of every local authority remained unfulfilled.

But while S.A.M.W. as a whole was devoting its primary energies towards mental defectives, its Mental Hygiene Committee took a rather different perspective. Although the Committee was established at the same time as S.A.M.W. itself, it became more influential during the latter 1920s and early 1930s. It was more interested in the prevention and early treatment of mental illness and nervous conditions. On an external level, it attempted through lectures, talks and the press to familiarise the public and statutory and voluntary bodies with the symptoms of incipient disorder, and with the

amenities available for their treatment. It was also involved in the establishment of four clinics.[56] On an internal level, it was concerned to correct what it saw as an imbalance in the Association's programme; and its determination to broaden the scope of S.A.M.W.'s work so as to include mental health in its wider sense bore fruit when, in 1929, S.A.M.W.'s aims were extended to include that of taking all possible steps to improve the community's mental health. The failure of the Committee's 1931 attempt to add 'and National Council for Mental Hygiene' to S.A.M.W.'s title was but a temporary setback, and the Association was increasingly coming to see defect as only one aspect of mental health.[57]

This shift in emphasis was further reflected in the development of a more intimate relationship between S.A.M.W. and the child guidance movement. The Association had always maintained close links with other voluntary bodies - including the Glasgow Association for the Care of Feeble-Minded Children and the S.S.P.C.C. - but its increasing interest in mental hygiene drew it nearer to an organisation with somewhat similar preoccupations; the Scottish Child Guidance Council. S.A.M.W. representatives served on the S.C.G.C. executive from the mid-1930s onwards and towards the end of the decade a special sub-committee which had been established to consider the Association's aims and constitution recommended an amalgamation between the two bodies. The union took place at the Annual General Meeting of May 1938.[58]

Thus was born the 'Scottish Association of Mental Hygiene'. To S.A.M.W.'s aims of supporting local care committees and helping individual cases were added those of promoting public education and interest in mental health and hygiene and of furthering the child

guidance movement.[59] Apparently because of the breadth of its aims, the new Association was to be organised on a federal basis. Three sections - mental health, mental deficiency and child guidance - which, it seemed, would be of approximately equal size,[60] would each develop the form of organisation which was most appropriate to its particular field of interest. Each group was to have its own separate meetings (although they would be on the same day and in the same venue) prior to the meeting of the Association as a whole. The first Annual General Meeting of the re-organised Association was held in June 1939.[61]

S.A.M.W. was the most prominent voluntary organisation in its field during the inter-war years. It was distinguished by its nation-wide perspective and organisation, the size and diversity of its membership[62] and its unparalleled network of local committees and voluntary visitors. It was also important as a pioneer of community facilities for mental defectives; in that capacity the Association performed the voluntary sector's classic role as an innovator of provisions which would subsequently become a statutory responsibility. However, the history of the Association in the inter-war years was also notable as a microcosm of wider changes. As the alteration in its title and aims eventually reflected, S.A.M.W. broadened its out-look to take an interest in the preventive and promotive aspects of the mental health service. The remainder of this chapter, and the next chapter, describes the extent to which at least the glimmerings of a similar shift were also apparent in other areas of the service.

(iv) The child guidance movement

The Association's concern with healthy mental development was,

in particular, part of a wider mental hygiene movement which also found expression in the work of the emergent child guidance movement. An increased interest in childhood psychological growth, and its impact upon the adult character, had been apparent since the late nineteenth century. Eugenists were drawn to child psychology from the standpoint of their concern about juvenile delinquency, and the mental testing movement also brought the problems of children with intellectual and other difficulties more sharply into focus. The intensification of interest in the years following World War One, however, was to some extent a product of the war. It highlighted the amount of 'hidden' mental disorder in the community, and concentrated attention upon the need for prevention and early detection. The occurrence of shell-shock and war-strain also seemed to point towards the importance of psychological factors in the causation of mental disturbance and, in particular, produced a wave of interest in Freudian theory, with its emphasis upon the significance of childhood experiences in the formation of the personality.

All these factors encouraged a widespread belief that, psychologically, the child was father to the man. There was a conviction that much mental disorder was the product of 'morbid emotional development' during the formative years.[63] It was widely accepted that 'the habits of ... youth are the lines of ... further development', and it followed that 'the moulding process' must begin in the 'pliable and elastic' stages of life.[64] The promotion of healthy emotional and moral growth in children, and the early detection of abnormality and deviance, was the cornerstone of the child guidance movement. It attempted to meet and treat aberration at the threshold.

The origins of the Scottish child guidance service, however, were firmly rooted in the Scottish educational tradition. Education and, by implication, teachers, had a high prestige, and behavioural problems were accepted as being within the teacher's province. The fact that, as already described, psychology formed an integral part of the curriculum for trainee teachers meant that when the interest in child guidance began to take practical shape, the Scottish mind naturally thought of it as a branch of education rather than, as in England, a sub-division of psychiatry. Thus, in the mid-1920s, when the early English clinics were being opened in association with the health service,[65] the first Scottish clinics were established, independently but almost simultaneously, at the Universities of Glasgow and Edinburgh; Dr. William Boyd of the Department of Education in Glasgow opened an educational clinic and James Drever, head of Edinburgh's Psychology Department, founded the University Psychological Clinic for Children and Juveniles.[66] Other educational establishments, including the Teachers' Training Colleges in Edinburgh and Dundee, and Aberdeen University, also opened child guidance clinics in the late 1920s and 1930s.[67]

However, at about the same time as these educationally and psychologically based clinics were being established, Scottish child guidance clinics with a more 'medical' inclination were also being set up. Notre Dame Clinic, opened at the Teachers' Training College for Catholic Women in Glasgow in 1931, was the prototype. The first Scottish clinic to call itself a 'child guidance clinic', it had (despite being founded by the psychologist Sister Marie Hilda) an 'avowedly psychiatric orientation',[68] and drew its inspiration as much from the psychoanalytic as from the mental measurement tradition.[69] A

number of clinics which combined the treatment of adult and juvenile psychiatric patients with child guidance - like the Paisley Clinic for Nervous Disorders and Child Guidance and the Perth Royal Infirmary Clinic[70] - were also established in the inter-war period, but psychiatrically orientated child guidance clinics remained in the minority.

All these early clinics were voluntary and the Scottish Child Guidance Council, formed in 1934, provided, during its short independent existence, some measure of co-ordination.[71] But there was a growing consensus that voluntary effort alone could not fully develop the service's potentialities: it was reflected in the (Cathcart) Committee on the Scottish Health Service which in 1936 recommended that local education authorities should be empowered to open clinics.[72] This proposal was not implemented but, nevertheless, the L.E.A. in Glasgow decided to act. In 1937, at the behest of the S.C.G.C., the first clinic under statutory auspices was opened in the City: it proved so successful that the L.E.A. opened two more clinics in the following two years.[73] A developing statutory interest in the service was also evident in Ayrshire where, in the late 1930s, the L.E.A. provided premises for a voluntary clinic,[74] but the pace of development was generally slow. Child guidance was still in its infancy, and L.E.A.s did not have specific powers to provide clinics; as a result, the voluntary sector that pioneered the service continued to play the major role in it during the inter-war years.

It is difficult to generalise about the work of the child guidance service in the period. The clients of the service came from a wide variety of sources; while many cases came via the school health service, others were referred by hospitals, family doctors, voluntary

bodies, probation officers or employers, or were simply brought by their parents. They also presented a wide range of problems; behaviour problems, emotional or psychological problems, speech disorders and neurotic symptoms. Many, however, had learning problems. The child guidance service was not part of the mental deficiency service and was not intended to treat deficiency. But since educational and other problems were sometimes the result of intellectual disability, the service did deal with many defectives. The assessment of ability - which involved the large-scale use of intelligence tests and educational attainment tests[75] - and the confirmation of suspected mental deficiency played an important role in the service's work.

The work undertaken by child guidance clinics also depended upon the staff who were available. In a few cases - as at Notre Dame Clinic - there was a psychiatrist on the staff,[76] but the primarily educational bias of the service generally meant that children presenting psychiatric problems had to be referred to one of the out-patient clinics at mental or general hospitals.[77] Psychiatric social workers were also a rarity in Scottish clinics during the inter-war years. This was partly because qualified P.S.W.s were in short supply,[78] but it was also a consequence of the Scottish bias towards teacher psychologists; these holders of the B.Ed. higher degree in education and psychology earlier mentioned were the mainstays of the Scottish service. Their pre-eminent position, and the general inclination of the Scottish service, was resented by those who believed that child guidance should be more psychiatrically disposed - in fact in the 1930s the S.C.G.C. attempted to establish the principle that only clinics controlled by medical doctors should be entitled to

the designation of 'child guidance clinic'.[79] This attempt, however, failed and the dominance of teacher psychologists ensured that the service was essentially non-medical.

About a dozen child guidance clinics were established in Scotland by 1939, in some of the larger towns - including Paisley, Clydebank, Greenock and Kilmarnock - as well as in all four cities.[80] There were some unresolved difficulties; child guidance was still largely an urban phenomenon and the psychiatric and social work components of the service were generally inadequate. The identity of the service - whether medical or educational, or a combination of the two - also remained to be settled. But if the service needed to expand before it became a truly national and comprehensive service it had, in little more than a decade, already made a significant contribution to the early detection and treatment of educational, psychiatric and psychological disturbances in children.

In general, however, the development of services for juveniles was patchy. While some progress was made in the areas of ascertainment and special education, statutory provision for those categorised as ineducable and for the over-sixteens was woefully inadequate, and there were limits to the extent to which voluntary effort could compensate for statutory shortcomings. Nevertheless, there were underlying trends which held out the promise of the development of a more complete service for mentally disordered juveniles; there was, in particular, an increased interest in prevention and early treatment - shown most clearly in the child guidance movement - and the growth of facilities - occupation and employment centres, as well as child guidance clinics - which were outside the institutional setting and which were not tied to a legal framework based on certification and judicial process.

Chapter 5 Early and Voluntary Treatment for Adults

(i) The impetus and obstacles to reform

(ii) The impact of limited change

(iii) Extra-asylum facilities

(i) The impetus and obstacles to reform

Similar trends to those which have been described in the last chapter were also evident in the mental health service for adults during the inter-war period. There was a parallel intensification of interest in prevention and early treatment, although, in this context, the emphasis was on treatment early in the course of illness rather than early in life. There was also a comparable stress on the development of treatment facilities which were outside the traditional institutional setting. Voluntary asylum treatment - treatment without certification and a Sheriff's order - had been sanctioned in Scotland since the mid-nineteenth century, and psychiatric observation wards were attached to a number of general hospitals. But the provision of a comprehensive early treatment service which was not largely restricted to those who could pay, to those who were seriously disturbed and to those who had undergone legal process required the expansion both of voluntary asylum treatment and of extra-asylum amenities. The aftermath of the war seemed a propitious period for this extension. The 1913 Act had speeded up and simplified the procedure for voluntary admission, the policy of treating mentally disordered servicemen without certification provided a working model of a mental health service which was less preoccupied with legalism, and, above all, the consensus of opinion was moving strongly in favour of early and voluntary treatment. The first two sections in this chapter describe the development of voluntaryism in the asylum service, and the growth of non-asylum treatment is discussed in the final section.

But why was voluntary treatment felt to be preferable to certified treatment? Firstly, and most importantly, voluntary

treatment was almost synonymous with preventive or early treatment. Treatment which commenced only after the patient had reached the certifiable stage could not, by definition, be preventive. Voluntary treatment, on the other hand, could begin in the incipient stage of illness, before the patient's condition became confirmed. Voluntary treatment was thus universally perceived to be more 'hopeful' and to greatly increase the patient's chances of recovery.

Concrete evidence with which to demonstrate the validity of this confident assumption, however, was not readily available at the time. There were indications that patients who entered asylums within a few weeks of the outset of their illness had a better chance of recovery than patients whose condition had been apparent for many months, or even years, before treatment.[1] But so far as voluntary and certified cases were concerned it is difficult to form an overall picture. The national statistics drawn up by the General Board did not distinguish between the results of treatment in certified and voluntary cases. Evidence from those asylums - like the Crichton Royal Institution - which did provide separate statistics showed that the recovery rate of voluntary patients was generally, though not invariably, higher,[2] but there were a variety of complicating factors. The ability to make an application for admission was a prerequisite for voluntary treatment, and patients suffering from general paralysis, senile dementia or, indeed, 'idiocy', were very unlikely to be able to do so. To contrast the recovery rates of voluntary and certified patients was therefore in a sense unfair; it was, to a large extent, measuring the results of treating patients with generally less serious and more transient forms of mental disorder against the results of treating patients with severe and often irrecoverable conditions. In

the circumstances, it is hardly surprising that the former group appeared to 'win'. Social class may also have been a factor. The point at which recovery was deemed to have taken place could be influenced by the home environment to which the patient was to be discharged; since voluntary patients were, in the years immediately after the war, invariably private patients, their more comfortable domestic arrangements could provide an added incentive for earlier discharge. There was, thirdly and most obviously, the fact that voluntary patients, unlike certified patients, were free to leave the asylum. And while voluntary patients were apparently more likely to be discharged as recovered, they were also more likely to be discharged as 'unrecovered' or merely 'relieved'.[3]

The evidence about the impact of early and voluntary treatment upon recovery, therefore, was often scanty, inconclusive and complex. In this context, however, it was the general perception that it increased the patient's chance of recovery which was most significant. Common sense alone seemed to suggest that early treatment was desirable, and an analogy was often drawn between mental and physical disorders; as Dr. Dods Brown, Superintendent of Aberdeen Royal Asylum, remarked in 1919, 'as is the case with all bodily illnesses, the sooner patients suffering from mental diseases receive proper treatment the better is the prognosis'.[4] Just as early treatment could prevent a wound festering and becoming gangrenous so too, it was felt, could early treatment prevent a minor deviation from the norm of mental health becoming something more intractable.

The comparisons drawn between mental and physical disorders were not coincidental. Certification was also felt to be undesirable because it was unmedical. The conviction that the mentally disordered

should be treated as much like the physically disordered as possible made the mass certification of the mentally ill appear increasingly unacceptable. The way in which it categorised the mentally ill as fundamentally different from the physically disordered was widely regarded as a distortion of their real relationship. The fact that many patients were admitted to asylums at such a late stage of their illness, and that they were usually compulsorily detained also made it harder for asylums to develop the hopeful, curative 'hospital' atmosphere which they were so anxious to promote. Many doctors also resented their involvement in compulsory commitment; in 1923 Professor Robertson, Superintendent of the Edinburgh Royal Mental Hospital, claimed that 'every medical man ... is opposed to the present system of certification'.[5] This was rather sweeping, but many of his colleagues agreed that certification was the most painful duty that they performed, since it detracted from what they saw as their proper role as healers of the sick.

Moreover, it was not only doctors who objected to certification. It is very difficult to disentangle the stigma which was attached to certification from the stigma which was attached to the condition which underlay it; but much of the post-war pressure for the extension of voluntary treatment was based on the conviction that much of the shame and disgrace associated with mental illness was the result of the committal process which so often accompanied it rather than of the disorder itself. It was the Sheriff's role in the procedure which was the particular focus of attention. It, it was argued, introduced a quasi-criminal element into the process, encouraged the view that the mental patient was a delinquent or a malefactor rather than a sick person,[6] and acted as a disincentive to treatment. Voluntary

admission, on the other hand, avoided the ignominy of certification and encouraged patients to seek help at an early stage.

In this climate which stressed voluntaryism, therefore, there was an increase in the number of patients entering asylums on a voluntary basis. The number of voluntaries admitted to Scots asylums in 1928 was, at 775, more than four times the 172 admitted in 1918 and the number of voluntary patients resident in asylums rose from 246 in January 1919 to 909 in January 1929.[7] In some asylums, voluntary admission had become the norm; almost two-thirds of all admissions, and more than three-quarters of private admissions, to the Crichton Royal Institution in 1928 were voluntary,[8] and, in the same year, more than half of all the admissions to the Edinburgh Royal Mental Hospital were on a voluntary basis.[9] The general trend, Professor Robertson asserted, was 'a revolution, and one of the most happy character'.[10]

But in the 1920s major obstacles still stood in the way of a further expansion of voluntary treatment. Three main problems can be identified. The first was stigma. While voluntary asylum treatment was free from certification and judicial process, this did not entirely eradicate the stigma attached to mental disorder and to asylum treatment. The 'unfortunate and cruel prejudices' which still surrounded mental disorder,[11] compounded by the fact that asylums were frequently isolated, gaol-like and generally unattractive institutions, could still act as potent deterrents to treatment on <u>any</u> basis.

Secondly, there was apparently some ignorance among prospective patients, and even, perhaps, among doctors, about voluntary treatment. Dr. Dods Brown, who discussed the problem in 1924, felt that the relative simplicity of the admission procedure was 'not ... understood as fully as it should be' and emphasised that voluntary patients could

not be kept against their will.[12] But the long-standing association between asylum treatment and compulsory detention could not be eradicated overnight. Nor, in fact, was such an association, even in the case of voluntary patients, unjustified. Voluntary patients were still required to give three days notice of their intention to leave and might even, in exceptional circumstances, be certified. The evidence suggests that this was, in fact, very rarely done.[13] But confusion about the rights of voluntary patients, and especially the possibility, however remote, that voluntary treatment might turn into something more permanent could make even voluntary treatment a rather alarming prospect.

The most significant restrictions upon voluntary treatment, however, were contained in the legal and financial structures which excluded certain groups of patients from it. Two categories could not, under any circumstances, receive voluntary treatment. These were, firstly, those whose condition rendered them incapable of expressing their willingness or unwillingness to receive treatment. The subjection of these patients to certification and judicial process - particularly when their condition was recoverable amd might require only short-term treatment - was increasingly regarded as unacceptable, and there was pressure for some sort of legislative change which would enable them to receive temporary asylum treatment without certification and an order: Professor Robertson, for example, consistently urged that certification and the Sheriff's order should be replaced by medical recommendation and the sanction of the General Board.[14]

There were, secondly, patients who were definitely opposed to treatment. There was some pressure for the reform of the committal process which was used for these patients; Professor Robertson felt

that in their case, too, the existing procedures could safely be abolished in favour of recommendation and the Board's approval.[15] Dr. Easterbrook, Superintendent of the Crichton Royal Institution, however, felt that certification was not such a disability in Scotland as it was in England, since the Scots certified patient, unlike his English counterpart, was not necessarily regarded as incapable of managing his or her own affairs.[16] But the debate centred on the machinery of committal rather than the principle which underlay it. It was accepted that where patients were unwilling to accept treatment, their interests, or those of society, made some sort of compulsion necessary. The compulsory treatment - in whatever form - of these patients was regarded as inevitable, and it was accepted that voluntary treatment could not be extended to them.

However, it was equally generally accepted that certification should not be a prerequisite for treatment but should be used only when medical or social necessity demanded it. This was certainly not the case under the existing structures, since a large number of patients who were willing to receive voluntary treatment were generally denied it. Two distinct categories of patient were involved. The first were those who were prepared to accept treatment but who were legally certifiable. The question of whether such patients could and should be treated on a voluntary basis was the subject of much debate in the inter-war years. It revolved, firstly, around the moral or philosophical question of whether patients who had reached the certifiable stage were competent to consent to treatment. The consensus of medical opinion, however, was that many certifiable patients were capable of recognising the nature and consequences of their actions, and thus of exercising free will. Most doctors

therefore felt that the decision to admit a patient on a voluntary basis should depend on the patient's desire to receive treatment, and not on his or her degree of insanity.[17]

It was, however, doubtful whether the law agreed. There was a question mark as to the legality of treating certifiable but willing patients on a voluntary basis. The terminology of section 15 of the 1866 Lunacy Act - which authorised the voluntary treatment of any person who was desirous of receiving it but whose condition was not certifiable - was open to interpretation; in particular, the use of 'but' rather than 'and' seemed confusing. It appeared, on balance, likely that the qualification was intended to restrict voluntary treatment to those who were not certifiable. Some felt that voluntary treatment was so restricted; the (Cathcart) Committee on the Scottish Health Services in 1936 was convinced that this was the case.[18] Others, however, including Professor Robertson, argued that this limitation (if it had existed) had been removed by section 59 of the 1913 Act.[19]

The legality of the voluntary admission of certifiable patients, therefore, was open to doubt. In the 1920s, some doctors who believed that any qualification of the patient's desire for treatment was superfluous took advantage of the loophole left by terminological inexactitude and admitted some certifiable but willing patients on a voluntary basis.[20] The frequency with which it was done, and the number of patients who were involved, however, is unclear. While the law did not prevent the voluntary admission of some certifiable patients, an elastic interpretation of the statutes was an uncertain basis upon which to build an expansion of voluntary treatment.

The exclusion of the vast majority of poorer patients from

voluntary treatment, however, was an even more significant limitation on the extension of the policy. The fourth category of those who were generally denied voluntary treatment were paupers. The way in which the financing of the service effectively excluded pauper patients from voluntary treatment has already been described in chapter 1, and the changes which had taken place in the meantime had not altered the situation. The grant from central government for the maintenance of pauper lunatics was still, in the 1920s, paid only for certified patients. While district boards were, under the terms of the 1913 Act, jointly liable for the maintenance of pauper lunatics, their financial responsibility was similarly restricted to certified lunatics and they had no duty to contribute towards the cost of voluntary patients. The cost of maintaining paupers as voluntary patients, then, still fell entirely on the shoulders of parish councils. The economic impossibility of their bearing this cost - and also, perhaps, the belief that patients who were not demonstrably (certifiably) ill should not be treated at rate-payers' expense - was, in the years after World War One, as effective a barrier to the voluntary treatment of parochial patients as it had been in the early years of the century.

In the mid-1920s, however, a breach was made in this virtual ban on the voluntary admission of pauper patients. A few parishes - including some in Argyllshire and Stirlingshire , and those in the cities of Aberdeen and Edinburgh - began to allow suitable parochial patients to be treated on a voluntary basis.[21] The encouragement of the General Board[22] and the dawning recognition of the desirability of voluntary treatment were partly responsible for this change, but in some cases special financial arrangements provided the local

authorities with an extra incentive.[23] As a result, the number of pauper voluntary admissions increased, and reached 114 in 1927.[24] That number, however, was still tiny: in fact, the number of paupers admitted on a voluntary basis to all Scots asylums in 1927 was identical to the number of private voluntary admissions to a single institution - the Edinburgh Royal Mental Hospital - in the following year.[25]

The unfairness of this was thrown into sharp relief in the 1920s as the number of voluntary private patients grew. The necessity to certify those who were unable to express a desire for treatment and those who were willing but certifiable could conceivably be justified on the grounds of safeguarding the liberty of the subject; but the necessity to certify those who were in every way suitable for voluntary treatment but who lacked the means to obtain it privately seemed indefensible, and was vociferously condemned as 'a hardship which cannot be rectified too soon'[26] and as 'obsolescent ... and objectionable'.[27] In this case, however, it was the link between lunacy and the Poor Laws, rather than the Lunacy Laws, which was the focus of attention, since the blanket certification of the poor was a consequence of their pauperism. As long as the relationship between lunacy and the Poor Laws remained in its existing form, the early and voluntary treatment of the majority of patients was retarded rather than facilitated. A truly preventive and promotive service seemed to demand the 'de-pauperisation' as well as the 'de-certification' of the majority of patients; mental illness, Dr. Easterbrook emphasised, was 'not an essential part of the problem of poverty'.[28]

(ii) The impact of limited change

The extent to which this aspiration was met by the Local Government (Scotland) Act 1929 has already been described in chapter 3. The transfer of responsibility for the mentally disordered to the omnibus local authorities, and of the liability for their maintenance to the county and town council rates effectively 'depauperised' the lunatic poor; although under the terms of the Lunacy Acts they remained 'pauper' lunatics, the term 'rate-aided' was increasingly used to describe them.[29] But the most important provisions of the Act so far as early and voluntary treatment was concerned were the new financial arrangements introduced in Part III. The per capita Pauper Lunacy Grant was abolished: the Government's contribution towards the cost of the lunatic poor was merged in the general Exchequer contribution - the Government block grant - paid to the new local authorities. This grant was not affected by patients' voluntary or certified status, and local authorities would not suffer financially if they allowed rate-aided cases to enter asylums on a voluntary basis. The economic deterrent against the voluntary treatment of poor patients was therefore removed.

The 1929 Act, however, tended to equalise rather than extend the opportunities for voluntary treatment. It did nothing to satisfy the pressure for reform of the provisions which governed voluntary treatment generally. In England, by contrast, sweeping changes were introduced. The English Local Government Act 1929 similarly 'depauperised' the lunatic poor south of the Tweed, but the changes did not stop there. The basic premise of the 1926 report of the English Royal Commission on mental disorder was that mental illness was a disease like any other; from this flowed its major recommendations

that the keynote of the future must be prevention and early treatment, and that certification should be a last resort.[30] The report was widely praised in Scotland - Professor Robertson described it as 'a wonderful achievement'[31] - but the Mental Treatment Act 1930 which encapsulated its proposals was confined to England and Wales. It did extend the provisions for early and voluntary treatment. It authorised, for the first time in England, the voluntary admission of rate-aided and other patients into local authority mental hospitals, and into other hospitals and nursing homes. It empowered local authorities to make arrangements for out-patient treatment in mental or general hospitals, and for after-care, and it also made terminological modifications; 'asylums' became 'mental hospitals' and 'pauper lunatics' became, officially, 'rate-aided patients'.

The most innovative feature of the English Act, however, was its creation of a new category - that of the 'temporary' or 'non-volitional' patient - which was, in effect, intermediate between the certified and voluntary groups. Its establishment was designed to protect from immediate certification those patients who were regarded as recoverable but whose condition rendered them incapable of consenting to treatment and who were therefore ineligible for voluntary admission. The procedure for temporary treatment required a relative, or other authorised party, to make an application for admission to the institution where the prospective patient was to be treated. This had to be supported by two doctors' recommendations (the term certificate was studiously avoided) stating the grounds for admission, and by the doctors' conjoint declaration stating that the patient was mentally ill and was incapable of expressing willingness or unwillingness to receive treatment. The completion of this process

authorised the patient's detention for six months, but the period of detention could be extended by another six months if the patient's chance of recovery demanded it.[32] The provision therefore removed, at least for a period of up to one year, both the need for certification and for legal formality in the treatment of some patients who were unsuitable for voluntary treatment.

The English Act's intentions were generally applauded in Scotland; Dr. Dods Brown felt that it marked 'a great advance ... in the treatment of mental diseases',[33] and Dr. Easterbrook described it as 'laudable'.[34] But there was some ambivalence about the application of its provisions to Scotland. There was, in particular, a widespread conviction that instead of adopting the English temporary patient category, similar results could be achieved by extending and strengthening the provisions of the Scottish Six Months Certificate. It had, since 1857, authorised the temporary treatment of patients whose insanity was not confirmed on the sole authority of a single medical certificate, but the provision was confined to private patients and authorised only the patient's reception into a private house or nursing home. In the early 1930s, however, there was a considerable body of medical opinion which held that the provision should be expanded to apply to all classes of patients - including the rate-aided - and to treatment in an asylum. This simple modification of an existing provision, it was felt, would be the best way of obtaining for Scottish patients the benefits of short-term asylum treatment without the necessity for judicial process.[35]

In fact, the expectations both of those who wanted a Scottish Mental Treatment Act and of those who urged an extension of the existing Scottish provision were destined to be disappointed. Despite

the general conviction in the early 1930s that some sort of Scottish legislation was imminent,[36] the Scottish Lunacy Laws were not amended. It is not entirely clear why this was so. The Royal Commission which inspired the 1930 Act had admittedly been confined to England and Wales[37] but, particularly in view of the consensus that modification of the Scottish temporary treatment provision would achieve the desired results, this does not, by itself, appear to provide an adequate explanation for the lack of change in Scotland.

It appears, therefore, that the lack of lunacy legislation in Scotland was primarily due to the fact that the need for change there was not so immediately apparent to those who were not intimately involved in the service. In England in the 1920s the necessity for reform was glaringly obvious. In Scotland, by contrast, voluntary patients were not restricted to private and voluntary asylums, temporary treatment without an order was available (albeit in a limited form) and certified patients were not necessarily regarded as incapable of looking after their own affairs. Scotland's long-standing and widely acknowledged superiority in these provisions masked the extent to which change was needed, and ultimately proved to be a disadvantage.

The debate about extending the provisions of the Mental Treatment Act to Scotland and the modification of the provisions of the Six Months Certificate continued throughout the 1930s and after-wards. At a grassroots level, however, the lack of legislation meant that the majority of Scots patients remained 'pauper lunatics' and the majority of institutions remained 'asylums'. It also meant that Scottish local authorities did not have the same powers as their English counterparts to provide out-patient facilities and after-care.

Table 5:1 Voluntary Treatment in the 1930s

Date	Number resident on 1 Jan. each year	Number admitted in 12 months preceeding 1 Jan. each year
1930	950	800
1931	972	734
1932	1038	771
1933	1056	803
1934	1088	801
1935	1190	843
1936	1213	855
1937	1327	900
1938	1405	1013
1939	1480	1109

Source: Annual Reports of the General Board of Control for Scotland

Table 5:2 Rate-aided Voluntaries in the 1930s

Date	Total number of voluntaries resident on 1 Jan. each year	Number of rate-aided voluntaries resident on 1 Jan. each year
1932	1038	233
1933	1056	235
1934	1088	250
1935	1190	303
1936	1213	322
1937	1327	373
1938	1405	416
1939	1480	459

Source: Annual Reports of the General Board of Control for Scotland

Above all, it meant that Scots patients who did not express a positive desire for voluntary treatment were, unlike their English equivalents, still subjected to certification and legal process. The extent to which the two countries' previous positions had been reversed was evident in the decline in the 1930s in the number of English private patients who came north of the Border for voluntary treatment.[38] They no longer had the incentive to do so. Until 1930, Scotland had been in the vanguard of provisions for treatment without certification. Afterwards, however, it lagged behind its southern neighbour.

However, so far as Scotland was concerned the trend of increasing voluntary admissions which had been established in the previous decade continued during the 1930s. It was, as Table 5:1 shows, not an unbroken increase, and growth was steady rather than dramatic; nevertheless, in 1938 almost one-third of the total admissions to Scottish asylums were voluntary.[39] Part of this overall increase was attributable to an increase in the number of rate-aided voluntaries; the 1929 Act did, as expected, lead to an expansion in voluntary treatment for this group. It is not easy to follow the increase in the admissions of voluntary rate-aided patients, since the General Board's admission statistics did not distinguish between them and private voluntaries. However, the number of rate-aided voluntaries resident in Scottish asylums did (as Table 5:2 shows) increase. From 1 January 1932 (when the Board first began to distinguish between aided and private voluntary residents) and 1 January 1939, the number of rate-aided voluntaries resident almost doubled, and, in the same period, the proportion of total voluntary residents who were rate-aided rose from less than one-quarter to almost one-third.

Table 5:3 The Royal Asylum Population, 1 January 1939

Asylum	Total no. patients	Certified patients	Voluntary patients	Rate-aided voluntaries
Aberdeen	921	855	66	18
Crichton R.I.	1028	709	319	27
Dundee	53	34	19	-
Edinburgh	914	643	271	33
Glasgow	555	396	159	-
Montrose	843	773	70	12
Murray	209	117	92	-

Source: Twenty-fifth Annual Report of the General Board of Control for Scotland for the year 1938, Appendix, Table V, pp. 9-10

Within this general expansionary picture, however, there were wide variations. The extent to which the voluntary method was utilised in individual asylums was influenced by a number of variable factors, including the economic class of the patients (since voluntary patients were still more likely to be private patients), the attitude of the superintendent, and, in the case of rate-aided voluntaries, the alacrity with which the local authority was prepared to permit uncertified treatment. Table 5:3 shows the number of voluntary patients resident in Royal asylums at the end of the 1930s. District asylums showed similar differences. Most district asylums accommodated a smattering of rate-aided voluntaries by 1939, but at the Edinburgh District Asylum, Bangour, they formed more than one-ninth of the total asylum population on 1 January 1939; in fact, on that date Bangour contained more than one-quarter of all the rate-aided voluntaries in Scotland.[40] At the other end of the scale, however, there were no voluntary patients in any of the Glasgow district asylums on 1 January 1939. Nor were there any in those storehouses for the chronically disabled, lunatic wards of poorhouses.[41]

Nevertheless, the fact that the general trend was quite clearly towards an increase in voluntary admissions held implications which extended beyond the most obvious one that more patients no longer underwent certification and judicial process in order to obtain treatment. It meant that the medical and nursing staff of many asylums were no longer dealing almost exclusively with those who were compulsorily detained; nurses, in particular, were less like prison warders and more like nurses in general hospitals. The changes in fact encouraged the 'hospitalisation' of asylums and this was reflected in the titles of three of them; the Edinburgh Royal Asylum

in 1927 officially became the Royal Edinburgh Hospital for Mental and Nervous Disorders, and the Aberdeen Royal Asylum and the Glasgow Royal Asylum made similar changes in the early 1930s.[42] These alterations were intended both to mirror and further encourage the gradual change in the institutions' function. The fact that more patients were voluntary may also have had an impact on the public's perception of the asylum service and of those who used it. There was certainly a widespread conviction that it encouraged more 'enlightened' and sympathetic views: the growing number of patients who entered asylums of their own accord was cited as evidence of the 'radically altered public attitude towards treatment in mental hospitals'.[43]

(iii) Extra-asylum facilities

The increasing number of voluntary patients in asylums, however, was only one aspect of the growth in provisions for early and voluntary treatment in the inter-war years. The period was also marked by an expansion of facilities for treatment outside asylums. The growth of these amenities - some for in-patient treatment, some for out-patient treatment and others offering a combination of the two - was in part a response to the difficulties which, particularly prior to the 1929 Act, stood in the way of the voluntary admission to asylums of poor patients; at a time when legal barriers effectively prevented early asylum treatment for paupers, the obvious solution was to provide that treatment elsewhere.

However, the extent to which extra-asylum facilities were developed for private patients (who did not experience the same difficulty in receiving asylum treatment on a voluntary basis) reflected the fact that other factors were involved. Patients with

relatively mild mental disturbances - or 'nervous conditions' - had previously attracted little attention, but the war had highlighted the extent to which emotional stress and mental strain could eventually lead to serious mental disorder, and focused attention on the group. The conviction that provisions were needed for those whose condition did not warrant even voluntary asylum treatment was therefore an important factor underlying the growth of extra-asylum provision.

So, too, was the conviction that treatment outside the asylum setting was less stigmatising, and thus was more attractive to prospective patients. Some doctors in fact took the argument a stage further. Opinions differed as to whether extra-asylum facilities should be provided in association with mental hospitals or general hospitals. Some doctors, including Dr. Chambers, Superintendent of the Murray Royal Asylum, Perth, felt that the amenities should be developed in conjunction with the existing resources of asylums,[44] but the general consensus was that facilities associated with general hospitals more accurately reflected the relationship between mental and physical disability and held more public appeal. But despite the fact that treatment in general hospitals did not, in Scotland, receive the specific encouragement of the community care provisions of the English Mental Treatment Act, both types of provisions were developed in the inter-war years.

Residential provision which was administratively allied to, but detached from, asylums was provided in a number of nursing homes opened in conjunction with Royal asylums. The first in Scotland was opened by the Edinburgh Royal Asylum in the closing months of World War One; during the years that followed, a number of others were gradually acquired and by 1930 there were ten properties under the

umbrella of the Hospital's 'Associated Nursing Homes'.[45] A number of other Royal Asylums followed Edinburgh's lead. A detached block - 'Gilgal' - was opened at the Murray Royal Asylum in 1930[46] and, in the following year, Wellwood Nursing Home, Cults, was established in association with Aberdeen Royal Mental Hospital[47] and Glasgow Royal Mental Hospital opened a nursing home at Cardross.[48] All these facilities catered for patients whose illness was expected to be of mild degree and short duration, and were confined to uncertified cases. All, too, treated only those of ample means.

There was an outstanding need for similar provision for those of more modest means, and particularly for paupers. The long-established form of extra-asylum treatment for this group - psychiatric observation wards in general hospitals - was expanded in 1924 when four wards of twenty beds each were opened at Glasgow's Stobhill Hospital.[49] Scotland's first 'Observation Hospital' was opened later in the decade. Jordanburn Nerve Hospital,which received its first patients in April 1929, was a new departure: although it was established in association with Edinburgh Royal Mental Hospital it had independent status as a voluntary hospital.[50] It was reserved for uncertified cases, who were drawn from all 'ranks of society'; patients who could afford it were expected to contribute towards the cost of their treatment, but a considerable proportion of cases were treated gratuitously.[51] The Hospital proved to be a conspicuous success and was intensively used; in 1936, for example, the number of patients admitted to Jordanburn, which had fifty beds, was almost identical to the number of admissions to the Edinburgh Royal Mental Hospital, which had 900 beds.[52]

While residential extra-asylum facilities were - with the

exception of observation wards - generally provided in association with mental hospitals, psychiatric out-patient treatment was generally developed in association with general hospitals. The Edinburgh Royal Mental Hospital had originally intended to open a clinic at the institution; but the conviction that patients would be averse to attending a mental hospital clinic, and the appointment of Professor Robertson as Consultant in Psychiatry to the Edinburgh Royal Infirmary in 1923, led to a change of plan and instead a clinic was opened at the Infirmary.[53] The 'T.T.' ('Tuesday at Two') clinic, as it was known, began in 1925 and was held, weekly, by Professor Robertson. Its success[54] led to the opening of an out-patient department at Jordanburn Hospital in 1929[55] and three years later Dr. McAlister, Superintendent of Bangour Asylum, organised a clinic at the Royal Victoria Dispensary.[56] Edinburgh, then, was particularly well served but by the 1930s there were also thriving clinics in a number of other areas, including Perth (the Royal Infirmary Clinic), Glasgow (the Western Infirmary Clinic), Paisley, Greenock and Dundee.[57]

The services that these clinics provided varied. Both adults and children were generally treated and some clinics - like the Paisley Clinic for Nervous Disorders and Child Guidance and the Perth Royal Infirmary Clinic - combined psychiatric out-patient work with child guidance.[58] A few clinics had the services of a social worker for domiciliary work; in 1930, for example, almost five hundred home visits were made by the 'social service worker' at the Edinburgh Royal Infirmary Clinic.[59] The fact that beds were not attached to the clinics meant that in general their work was more diagnostic and advisory than therapeutic: Jordanburn Clinic, however, was an exception to this rule, since the Hospital with which it was

associated functioned, to a large extent, as the clinic's residential unit.[60]

However, while out-patient clinics had their individual differences, their impact, and that of the other extra-asylum provisions which have been described, was broadly similar. Their development further narrowed the gulf between the mental and general health services. Patients in these facilities were not only treated on the same basis as the physically disordered - without certification or compulsory detention - but in many instances were treated under the same roof: the Cathcart Committee's endorsement, in 1936, of siting psychiatric clinics in general, rather than mental, hospitals also held out the promise that the process would accelerate.[61] The 1929 Act had provided the legislative foundation for a more cohesive mental and general health service, and the expansion of observation wards and clinics in general hospitals had fleshed out the skeleton.

Extra-asylum facilities also played an educative role. In some cases, it was explicit; both the Western Infirmary Clinic and the Edinburgh Royal Infirmary Clinic were used as teaching centres to familiarise medical students with the nervous and mental illnesses which they would meet as general practitioners.[62] But the growth of the new amenities also had a broader and less well-defined educative function. It is impossible to quantify the effect of extra-institutional developments upon the public's perception of mental disorder and its sufferers. But the fact that treatment was increasingly given in the openness of the community rather than behind the closed doors of asylums did seem conducive to the growth of more positive public attitudes.

By the end of the 1930s, therefore, the asylum had ceased to be

almost the sole therapeutic setting. Many patients had the opportunity for treatment in a residential unit detached from an asylum or associated with a general hospital, and many others were treated as out-patients while remaining in their homes and jobs; in fact Dr. Easterbrook in 1936 estimated that approximately one-half of those with mental or nervous breakdowns did not reach asylums, but recovered in nursing homes, observation wards or clinics.[63] Psychiatry, as Professor Henderson, newly appointed Superintendent of the Edinburgh Royal Mental Hospital, remarked in 1932, was gradually becoming 'not so much an institutional as a community affair'.[64]

However, it was overly-optimistic to assert, as Professor Robertson did in 1927, that the day of the certified lunatic was 'fast drawing to a close' in Scotland.[65] The accumulation of patients - particularly the chronic and senile - meant that even by the end of the 1930s the vast majority of patients in Scots asylums were certified.[66] Many hurdles still stood in the path of a comprehensive preventive and early treatment service. While the unreformed legal basis of the service had not entirely blocked the developments described in this chapter, it appeared that some fundamental legislative change was necessary if voluntaryism was to be fully utilised. The legal association between mental disorder and pauperism also remained, albeit in a diluted form. There were non-legal problems too. Despite the efforts of some clinics, general practitioners were generally inadequately equipped to act as the first line of attack on, or defence against, mental disorder. Extra-asylum facilities were largely confined to cities and the larger towns. The stigma of mental disorder also endured; old suspicions and prejudices may have been dying but they were far from dead. For all these reasons, a mental

health service rather than a service for the mentally disordered was still, as the Cathcart Committee declared in 1936, 'a tendency or aspiration rather than something that is in actual operation'.[67]

Chapter 6 The Therapeutic Milieu

(i) Eugenic sterilisation

(ii) Occupational therapy

(iii) Psychotherapy

(iv) Physical treatments

This chapter discusses four forms of treatment for the mentally disordered in the inter-war years. The first, eugenic sterilisation, was a prospective treatment which was never actually implemented; it is, nevertheless, in many ways the most interesting of those described, because of the light that it sheds on the concerns of mental health interests in the period. While eugenic sterilisation was the most controversial of the four, occupational therapy caused little debate, and was almost universally adopted. Psychotherapy, and the new physical treatments, occupied an intermediate position on the scale; they received a mixed reception. All the treatments, however, were part of the therapeutic milieu of the period, and their development illustrates the response of the mental health service in Scotland to new methods.

(i) Eugenic sterilisation

The part played by the eugenist movement in the agitation for reform before the First World War has already been described.[1] In the years following the war there was renewed concern about degeneration of the national stock and a resurgence of interest in the eugenist proposals for combatting the perceived decline; indeed, the inter-war period was the 'golden age' of the movement. The war seemed to strengthen the case for radical action, since it accelerated the process which, eugenists believed, was already evident before it.[2]

> During the fighting, the young, strong and healthy - or 'the more chivalrous, the more virile, the more courageous [and] the more patriotic'[3] - suffered heavy casualties. The lunatic and the mentally deficient, by contrast, had escaped the slaughter. The loss of the cream of a generation of men appeared to many to hold serious impli-

cations for the mental capacities of the nation as a whole; the process of natural selection, with its inexorable tendency towards the elimination of the unfit had, it seemed, been inverted. Eugenist proposals to halt the supposed deterioration thus held considerable appeal for those who feared an impoverishment of the race. A programme of 'negative' eugenics, which aimed to slow down the reproduction rate of those who were thought likely to transmit diseases or defects to future generations, was at the core of the eugenic policy of the inter-war years, and the surgical sterilisation of the unfit was its central plank. This section examines the pressure for the eugenic sterilisation of the mentally disordered, and analyses the reasons for its final frustration.

A conviction that hereditary factors played a major role in the causation of mental disorders underpinned the pressure for eugenic sterilisation. In the inter-war period, there developed a more sophisticated and elastic conception of the part played by heredity. In the case of mental illnesses, it was generally believed that schizophrenia and manic-depressive psychosis had a significant hereditary component. There was little evidence for the genetic transmission of other forms of mental illness, however. Hereditarians faced the problem that, in many cases, the relatives and parents of the mentally ill did not appear to be mentally disordered, and were frequently thoroughly stable or even 'exceptionally capable' individuals.[4] This did not, however, defeat those who adhered to a hereditarian viewpoint. While acknowledging that many forms of mental illness might not be directly transmissible, they believed that what was inherited was a tendency or predisposition towards mental illness, which might lie dormant until activated by some external

precipitating factor or event. Heredity thus provided a weak spot through which mental disorder could attack, and acted as a barrier to the possibilities of mental health.[5] This view was accepted by the Cathcart Committee which, in 1936, declared that some people would, because of their hereditary constitution, be less fit than others no matter what was done by way of medical care or environmental modification.[6] Base metal, in the analogy of Professor Henderson, could not be transmuted into gold.[7]

Hereditarians also encountered difficulty in attempting to trace mental deficiency to a morbid genetic endowment. Even convinced eugenists admitted that a direct hereditary causation could not be established in many cases and Blacker, General Secretary of the Eugenics Society, acknowledged that not more than one-tenth of all defectives had even one parent who was certifiable defective.[8] They were not discouraged, however. Some were convinced that more thorough investigation of the family backgrounds of defectives would reveal a greater role for heredity. Others believed that while the parents of many defectives might not be certifiable within the meaning of the Acts, they were subnormal or a little below par,[9] and were carriers of the condition which manifested itself in their offspring. Some, indeed, appeared to need little evidence to back their claims. William McKechnie baldly asserted that 80 per cent of mental deficiency had its roots in heredity.[10] The Cathcart Committee stated that 'every degree of mental deficiency may have a basis in heredity', even though witnesses to it had given widely varying estimates on heredity's role.[11] It is not clear how the Committee reached the conclusion that it did, but there was a strong eugenist presence on it.[12]

Thus, while evidence for the genetic transmission of mental disorder was confined to a limited number of conditions, heredity was generally seen as a major determinant of mental fitness. In some cases, those who accorded it a prominent place in the causation of mental disorder refined their arguments to circumvent the lack of hard data, while in other cases they did not appear to require substantiation. A belief in the significance of genetic endowment did not, of course, lead automatically to endorsement of a policy of sterilisation. It did, however, mean that support for provision for curbing the reproduction of the mentally disordered was more likely.

Financial considerations also played a part in the case for eugenic sterilisation. The rising costs of the service for the mentally disordered encouraged some to seek a means of cutting the bill, or at least of holding it at an acceptable level, by curbing the reproduction of the mentally disordered. Dr. Keay, Medical Superintendent of Bangour Asylum, deplored the fact that, in his view, expenditure on the mentally disordered was 'unproductive', since most of it was spent on those who were permanently disordered and who would be a burden on the community for the rest of their lives. He did not advocate any immediate reduction in expenditure, but recommended that economies should be made in the long term by limiting the numbers of the mentally disordered.[13] Blacker deplored the presentation of eugenic sterilisation as a money-saving alternative,[14] but it was admitted that the national economy was 'a powerful secondary argument for negative eugenics'.[15]

It was, however, alarm about the likely consequences of differential fertility which lay at the heart of the pressure for eugenic sterilisation. The belief that superior stocks were dying out

while the unfit continued to multiply provoked fears of progressive - or regressive - racial vitiation. Surprisingly, perhaps, proponents of the theory were not always in agreement as to the root cause of the process which was such an essential part of their case. Some believed it was linked to the strong sexual urges that mental defectives, particularly of the higher grade, were thought to possess. Differential fertility was, for them, a simple matter; the feeble-minded were 'mating and breeding twice as fast as normal people'.[16] Others, however, developed more sophisticated concepts. Blacker felt that the fertility of mental defectives was not, in general, abnormally high, and believed it was untrue that, on average, more children were born to defectives than to 'normal' citizens. It was, rather, the fertility of the 'social problem group' - the 'defective producing classes' - as a whole which was high, in consequence of the increase in the survival rate of those in the group. The reproductive differential was further compounded by the growth of the practice of family limitation among those whom eugenists regarded as socially useful. Differential fertility was thus felt to be the result both of the lower mortality rate of the eugenically dangerous and the increased use of birth control by the eugenically valuable.[17]

However, while the exponents of the theory of differential fertility may have differed slightly in their explanations for the phenomenon, they were united in their belief that its consequences were harmful. If nothing was done to check the perceived increase in the unfit then, in the words of John Keay, their ascendancy was 'simply a question of time'.[18] Evidence seemed to underline the need for action. Fuel for stoking the intelligence crisis came from a growing number of social and demographic surveys, including those of

Godfrey Thomson, Professor of Education at Edinburgh University from 1925.[19] Most importantly, the Wood Committee, in 1929, appeared to demonstrate that the incidence of mental deficiency had almost doubled since 1908.[20] Some felt the need for further investigation; the Scottish Council for Research in Education was prompted to undertake its survey of the intelligence of Scottish schoolchildren partly because of the 'generalisations of an alarmist nature' which had been made on the increase in mental deficiency.[21] Others, however, were already convinced of the urgency of the situation.

All these factors, though, do not fully explain the pressure for the sterilisation of the mentally disordered. The evidence for the genetic transmission of many physical disorders was at least as strong as that for the genetic transmission of mental disorders: the physically disordered, too, might be a life-long burden on the national economy, and might produce offspring who would prove a financial burden in their turn. Yet the interest in eugenic sterilisation was almost entirely focused upon its application to the mentally disordered. This apparent discrepancy derived from the widely held view that the mentally disordered - and particularly the mentally defective - were a threat to the community in a way that the physically disordered were not; that they were, in fact, a social menace. The existence of a social problem group was a cornerstone of the eugenics creed, and this motley collection of misfits - habitual paupers, criminals, unemployables, prostitutes and inebriates - was believed to contain a high proportion of mentally disordered people, particularly those 'primary aments' whose defect was due to hereditary factors. This assumption of a link between mental disorder and anti-social behaviour received considerable support in

Scotland in the period from those who believed that mental defectives, with their 'perverted' outlook and 'darkened, twisted ... minds',[22] were prone to lawlessness and immorality. Many perceived a close relationship between mental defect and a myriad of sexual evils - prostitution, venereal disease and illegitimacy - and criminal activity. Indeed, McKechnie, who felt that many uncontrolled defectives 'sank into the depths of degradation', went so far as to assert that the greatest single cause of delinquency generally was mental defect.[23] Although illicit and depraved tendencies were not generally believed to be directly transmissible hereditarily, the underlying condition of mental defect believed to prompt them was thought by eugenists and others to be so transmitted. Thus, the perceived inclination of the mentally disordered towards vice acted as a powerful stimulus to the pressure for their eugenic sterilisation.

The concept that mental disorder had an important hereditary component, that the mentally disordered were a burden and a menace, and that they were increasing, then, found considerable support in Scotland during the 1920s and 1930s. For those who accepted them, these premises pointed clearly to the necessity of taking prompt action to prevent - or at least slow down - the reproduction of the mentally disordered. Surgical sterilisation, though, was not the only, or even the most obvious, means by which this could be accomplished. Encouraging the mentally disordered to avail themselves of the contraceptive methods which had depressed the birthrate of the middle-class, for example, would appear to have been a convenient and simple way of achieving the desired result without the complication of surgery. Surprisingly, though, this did not attract widespread support. Moral objections probably played a part, but, in addition,

the mentally disordered were felt to be psychologically incapable of exercising the necessary self-discipline, and there was, as Blacker pointed out, no foolproof contraceptive method.[24] Another alternative to sterilisation - barring mental defectives from marrying - received limited support, but it, too, would not necessarily prevent procreation and would deprive defectives of the 'stabilising influence' of matrimony.[25] The policy of 'sterilisation' by segregation received more enthusiastic endorsement; Dr. Keay was among the advocates of the establishment of permanent 'industrial colonies' for the life-long detention of defectives.[26] Generally, however, supporters of the eugenics movement saw segregation as an auxiliary, rather than an alternative, to surgical sterilisation. While they felt it would be a very good long-term investment, they recognised that it would, in the short-term, be very expensive. It was suitable, and necessary, for defectives with pronounced anti-social tendencies (which sterilisation would not eradicate), but it was not felt to be an appropriate provision for those whose only probable 'anti-social' activity would be procreation.

Support for eugenic sterilisation among Scots psychiatrists was limited. Some did take a strongly eugenic line. Dr. Keay and Professor Henderson both debated the question of compulsory sterilisation. Dr. Keay did not find the idea morally objectionable; too much attention, he believed, had been paid to the liberty of the individual and not enough to the condition of the nation as a whole. However, he rejected compulsory sterilisation on practical grounds; he felt that it would be unworkable, and was unacceptable to the public.[27] Professor Henderson rejected it on similar grounds, believing that such a step would be much too far in advance of public opinion, which

was still much too complaisant regarding 'the huge social, economic, family and racial burden which mental illness and defect entail'.[28] The stress laid on public opinion is significant. At a time when psychiatrists were encouraging patients to enter asylums voluntarily, and developing extra-institutional facilities for early treatment, they were anxious to avoid anything which might discourage people from seeking treatment, and the prospect, however remote, of compulsory sterilisation would have been liable to do just that. Its introduction, with accompanying legal procedures and safeguards, would also have flown in the face of all the efforts psychiatrists were making to free the mental health service from cumbersome administrative and judicial processes.

Even sterilisation on a voluntary basis raised very difficult questions. The mentally disordered were in an almost uniquely vulnerable position and, even under the strictest safeguards, sterilisation would be open to abuse and exploitation. Legalising it only for those who were not certified would seem to defeat the object of the policy. However, could those who were certified give any real 'consent' - with the free will and full knowledge that the term implies - to their own sterilisation? If they were not able to consent, who should be allowed to so so on their behalf? The question of a patient's volition had proved difficult enough in the case of voluntary admissions to asylums :it seemed likely to pose even greater difficulties where an irrevocable surgical procedure was involved. Some psychiatrists, then, based their rejection of voluntary sterilisation on the premise that it would be tantamount to allowing those who were by definition incapable of doing so to legislate for themselves - an 'unthinkable' proposition.[29] Others felt

that, in any case, it would not achieve the desired results, and that the effect in countries where it had been introduced did not bear out the claims of those who urged it in Scotland. Thus, while Professor Henderson felt that sterilisation in the interests of the individual was acceptable, if used in selected cases for 'therapeutic' purposes, he rejected sterilisation on eugenic grounds, believing that it would make 'no material difference to the race as a race'.[30]

For a variety of reasons, therefore, most psychiatrists adopted a cautious approach. While many believed that some more radical approach to the problem of mental disorder was needed, they generally refused to be stampeded into supporting the introduction of panic legislation or a make-shift law which was of doubtful viability and morality. The Scottish Lunacy Laws were framed with a view to protecting the liberty of the subject; indeed some, like Dr. Keay, felt they were too preoccupied with it. Sterilisation, whether voluntary or compulsory, held serious implications for individual freedom . It is significant that, in many instances, eugenic sterilisation held more appeal for those working in other medical and scientific disciplines, where such questions did not so routinely arise as they did for psychiatrists.

It is difficult to gauge the extent of support for sterilisation among voluntary workers in the mental health field. The implication made by some eugenists that the work of voluntary organisations, by fostering and preserving the unfit, was actually harmful or 'dysgenic' in its effects might have been expected to alienate volunteers. However, the views of what has been termed the 'Better Dead' school[31] did not prevent many voluntary associations supporting sterilisation; the National Council for Mental Hygiene and

the Central Association for Mental Welfare both advocated it.[32] But the Scottish Association for Mental Welfare, the main Scottish body working in the area, does not appear to have endorsed the policy; indeed, at S.A.M.W.'s Annual Conference in May 1931, Dr. Clarkson, Superintendent of Larbert Institution, made a strong indictment of sterilisation.[33] Some members did, however, hold strongly heredi-tarian views and some of those closely associated with eugenics - including Dr. Shepherd Dawson - were S.A.M.W. members. There was some interest in sterilisation within the Association; in the late 1930s, a joint meeting of the Mental Hygiene and Mental Deficiency Sub-Committees was held for the purpose of obtaining the members' views on the subject. But among those who took part - and they were mainly doctors - there was a considerable difference of opinion as to the part played by heredity in the causation of mental disorder, and as to the desirability and probable effectiveness of sterilisation. However, all those who attended agreed that '<u>voluntary</u> sterilization could not have any appreciable effect upon the incidence of mental deficiency'; the use of the italic suggests that some members favoured some sort of compulsion, but the report is not explicit.[34] The only generalisation that can be made is that such a heterogeneous body as the Association contained a wide range of opinions on sterilisation.

Nevertheless, the extent to which eugenists had succeeded in making sterilisation a real issue was shown by the appointment of a Departmental Committee of the Ministry of Health, under the chairman-ship of the Chairman of the English Board of Control, to investigate the question. The Brock Committee reported in 1933. It rejected the case for compulsory sterilisation, but was unanimously in favour of allowing the voluntary sterilisation of the mentally disordered;[35] it

based its decision on the evidence of the hereditarian nature of mental disorder and the 'dead weight of social inefficiency' and individual misery which resulted from it.[36] It thus recommended that sterilisation should be legalised for mental defectives and for those who had suffered from mental illness, and for those believed likely to transmit mental illness or defect.[37] Since it recognised that it was treading in controversial waters, it stressed that there must be the fullest safeguards to ensure that sterilisation was really voluntary, and it emphasised that patients must not be tricked or cajoled into a hasty decision or unreal consent.[38] It was at pains to stress that voluntary sterilisation was not the thin end of the wedge of compulsion. But despite its thoroughness and apparent moderation, the Report did not convince many of those who had not previously been persuaded of its case. Although Professor Henderson, for example, found it 'excellent', and believed that it contained 'information of great value which should be widely diffused',[39] he did not alter his views on the inadvisability of sterilisation. Indeed, by the time the Brock Report was published, the factors that would ensure the defeat of its proposals were already in evidence, and no attempt was ever made to implement its recommendations.

Why, then, did the pressure for sterilisation ultimately fail? So far as Scotland was concerned, there was nothing really distinctive about the movement of opinion; in Britain as a whole, too many influential groups were either doubtful about eugenic sterilisation, or openly hostile to it. While some doctors favoured it, the profession as a whole was not convinced that sterilisation in the interests of the race was either desirable or practicable, and the British Medical Association remained aloof.[40] Many Roman Catholics

disapproved of sterilisation on religious grounds, and the opposition of the Church intensified following the 1930 Papal Encyclical which condemned it.[41] Parliament, crucially, was not persuaded. While some prominent individuals were sympathetic to the eugenists' case, the National Government was unwilling to run the risk of supporting such a controversial policy.[42] The depression may also have helped to undermine one of the central planks of eugenist theory, that those who rose in the social scale did so because of socially valuable qualities which were largely innate and at least partly hereditary, and that those who sank did so because of character defects which were likewise innate and hereditary. While, in the short term, the depression may have appeared to be a vindication of the eugenical creed, in the longer term the theory that social dependence and destitution were attributable to genetic factors became more difficult to sustain when mass unemployment affected those who were patently competent.[43]

The eugenics movement was also affected by events in Germany. The development of eugenic sterilisation in that country had been closely watched by British eugenists.[44] Even those who were not convinced of the merits of the eugenists' case had, like Professor Henderson, been extremely interested in the 'social experiments' carried out there.[45] As the oppressive nature of the Nazi race purification scheme became apparent, however, there dawned the shocked realisation of 'the evil purposes to which eugenics could be put'.[46] The Eugenics Society made strenuous efforts to dissociate itself from the excesses of the Nazi sterilisation campaign, but it, and British eugenics in general, still ran the very real risk of being found 'guilty by association'.[47] The German example of the way in which eugenist theory could be used to justify racialist rostrums helped to

create a distaste for negative eugenics, and hampered those who were anxious to effect the legalisation of sterilisation in Britain.[48]

However, while these factors served to weaken the case made by advocates of sterilisation, perhaps the most important reason for their failure was that they had not proven the case for the overwhelming significance of heredity in the causation of mental disorders. Investigators were unable to frame experiments conclusively to demonstrate the role of hereditary factors in determining mental endowment. Attempts to work out the inheritance of mental diseases on Mendelian lines seemed to many to be indeterminate and unconvincing, and had also raised the awkward genetic and eugenic problem that an apparently normal individual could be the carrier of morbid genes. Even the General Secretary of the Eugenics Society was forced to admit that 'no mathematically exact answer can ... be given to the question of how much mental defect is hereditary', and, he acknowledged, in the case of mental illness the answer was even more elusive.[49] It became clear that the eugenist case for the hereditarian nature of mental disorder was to a large extent based on personal philosophies and unstated assumptions - or 'prejudice and sentimentality'[50] - rather than on hard facts. There was a groundswell of opinion among Scots psychiatry in the 1930s that more exploration was necessary before a final conclusion could be arrived at. Dr. Easterbrook felt that much more work remained to be done in the vast field of morbid heredity.[51] Professor Henderson, too, called for further experimentation and investigation, and added 'it is education and knowledge more than legislation that we need at this stage'.[52] The Cathcart Committee also recommended organised research into the subject of heredity and its relation to the health of the community.[53] Until such inquiries

yielded verifiable results, most psychiatrists chose to take the middle path. Many believed that mental illness had a dual causation, that the mental endowment of the individual was due to the interaction of nature and nurture, and that constitution and environment were complementary. Most accorded an important place to heredity but, in the absence of concrete evidence, were not prepared to adopt a doctrinaire stance, especially in relation to mental illness, where cause and effect could only occasionally be brought into accurate correlation.[54] Psychiatrists generally agreed that in the circumstances, 'it would be well ... not to emphasise unduly the bogy of morbid mental heredity', upon which the case for eugenic sterilisation largely rested.[55]

The second major tenet of the eugenics movement - that of differential fertility and its adverse effects on the national intelligence - was also subjected to increasing criticism in the 1930s. It seemed to be undermined by new evidence which suggested that the birth-rate differentials between the classes were, contrary to the eugenists' assertion, actually becoming less pronounced.[56] Most importantly, eugenists had not offered convincing evidence that the differential birth-rate, if it existed, was really lowering the mental endowment of society as a whole. Eugenists again faced the problem that they had little concrete evidence with which to support their hypothesis and persuade doubters. The Cathcart Committee accepted that the hereditary constitution of the race was in continuous process of change, and believed that the direction of change was determined partly by the type of persons who were reproducing. But though it felt that the differential birth-rate between the social classes was bound to be affecting the 'mental quality of the race', it added that

'there is not enough evidence to justify a conclusion as to whether the change is for better or worse'.[57] Others also felt that the eugenist claims of race suicide had not been substantiated. Dr. Shepherd Dawson believed that 'the suggestion that the relative increase in the number of dullards will in time swamp the intelligent members of the community is not supported by evidence'.[58] Dr. Easterbrook was cautious about the effect of the 'apparent' failing fertility of the better-off,[59] while Professor Henderson, though believing that the problem of mental disorder was a vital matter deeply affecting the welfare of the race, stressed that there was no need to paint an alarmist picture of national mental decline.[60] The case that eugenists made, then, was for many not strong enough to demonstrate the necessity for such a radical step as sterilisation. The concept of differential fertility did not disappear overnight, and the issue lingered on for a number of years. But nevertheless, as John Gray accurately forecast, the eugenists' failure to corroborate the theory meant that the days of eugenic propaganda were already numbered.[61]

In the 1920s and early 1930s, the sterilisation lobby had been influential enough 'to be taken seriously in the general political arena'[62] and, particularly after the publication of the Wood and Brock Reports, had appeared to be on the threshold of considerable legislative impact.[63] But, for the reasons described, the eugenics movement in Scotland, as in Britain as a whole, did not achieve the concrete gains that it had in Germany and America.[64] In the second half of the 1930s, its influence, and the pressure for sterilisation, began to decline. Eugenism did not disappear, but its impetus had been largely dissipated by the outbreak of World War Two. Those who

were still concerned with the quality of the race increasingly turned to the positive aspects of eugenics - the stimulation of the fertility of the 'better' stocks - which had hitherto occupied a secondary place in the campaign. Efforts to encourage the birth of children who were likely to prove an asset to the State were applauded by Professor Henderson, who believed that the introduction of child allowances would be a distinct help towards that end.[65] The shift of emphasis was, to some extent, an admission of failure; the enemies of eugenics - 'mental inertia, political timidity, traditional prejudice and religious and sentimental opposition' - had triumphed.[66]

The eventual lack of success of the eugenics movement, however, does not diminish its significance, as the attention which it has attracted from those from a variety of disciplinary backgrounds suggests. It was a movement which was very much of its time; while eugenists were active before World War One, a policy of sterilisation - with its collectivist emphasis on the needs of society as a whole - did not attract much interest in an era of greater individualism, and it seemed anachronistic in the age of the welfare state, with its increased stress on the rights of the individual. It was also a paradoxical movement. It claimed a scientific rationale, and cited scientific evidence - Farrall describes it as 'one of the most sustained and vigorous attempts to apply scientific methods in the realms of political theory and social legislation'[67] - which, nevertheless, did not appeal to many of those with a scientific (or medical) background. It was also used as a vehicle for the expression of prejudice against the mentally disordered which had little to do with science.

The sterilisation lobby, however, should not be seen as an

aberration. Concern for the quality of the race was a subterranean thread which informed many of the developments of the inter-war years. The links between eugenics and the mental testing movement have been explored,[68] but less attention has been paid to its association with the increased emphasis on the prevention of mental illness. Sterilisation was not seen as applicable to mental defectives alone, and the pressure for its application to the mentally ill was, albeit in a tangential way, part of the continuum which produced the facilities for the prevention and early treatment of mental illness which have been described in earlier chapters.[69] It was also part of the therapeutic milieu which this chapter is concerned with; sterilisation, though, was intended to ameliorate the 'disorder' of society as a whole rather than that of the individual. The remainder of this chapter discusses the development of therapies aimed at the individual.

(ii) Occupational therapy

The most popular non-physical treatment used during the inter-war period was occupational therapy. The therapeutic value of recreation and activity for mental patients had long been recognised. It had been an important part of the 'milieu therapy' practised by the nineteenth-century 'moral managers',[70] and it was extensively used in some of the Scottish Royal asylums.[71] Modern occupational therapy, however, was introduced to Great Britain in the years following World War One. It differed from its nineteenth-century ancestor; it was largely shorn of class demarcation[72] and was seen as an integral part of the range of healing agencies. The beneficial results of the therapy stimulated widespread interest. In 1925, the Aberdeen Royal Mental Hospital, following the example of the Glasgow Royal and

Paisley District Asylum, established an occupational therapy department,[73] and, in the following year, the Edinburgh Royal Mental Hospital opened a similar department under the charge of a qualified instructress.[74] An 'Arts and Crafts Pavilion' was erected at the Crichton Royal Institution in 1928.[75] There were variations in the facilities available in these early O.T. departments, and thus in the type of work undertaken, but all taught a variety of handwork, such as basket-weaving, leatherwork, woodwork and toy-making.

The results of the new therapy were impressive, and its benefits were widely praised.[76] The General Board of Control was an enthusiastic supporter of O.T.,[77] but was careful to stress that its therapeutic, rather than economic, value must be paramount; it must not, the Board emphasised, be used as a means of securing from the patients' labour a measure of return for the cost of their maintenance.[78] The Board did not object to the common practice of holding sales of work to market the products of the patients' labour, however. There is no evidence, in fact, that the therapy was abused; its possible material benefits do seem to have been regarded as wholly subsidiary to its therapeutic advantages.[79]

The 1930s saw the further expansion and development of occupational therapy. The Scottish Association of Occupational Therapists was formed in 1932, and the supply of trained therapists gradually increased. O.T. was introduced into some asylums for the first time, while others which had previously adopted it improved their provisions; in 1938, the Crichton Royal Institution opened Easterbrook Hall, which provided unparalleled facilities for occupational and recreational therapy.[80] O.T. had come into general use in Scottish asylums by the outbreak of World War Two. In its

relatively short history, it had proven itself to be that rare therapeutic phenomenon - an unqualified success.

(iii) Psychotherapy

In the years immediately following the war, there was an increasing interest in the application of psychotherapy - including Freudian psychoanalysis - in the treatment of mental disorders. It was stimulated by the experience of treating shell-shocked servicemen during and after the war. It seemed to point towards the importance of psychological stresses in the causation of mental illnesses, and to confirm that the mind was capable of 'automatically and involuntarily exerting almost unlimited powers over the actions of the individual'.[81] It convinced some psychiatrists that progress in the treatment of mental illnesses would not be made through physical or organic treatments but, instead, that mental symptoms were to be solved by psychological means, and that recovery could best be obtained through 'treatment of a mental character'.[82] While it might be an exaggeration to say that psychotherapy 'burst like a new revelation on the profession in general and on the public',[83] it certainly created widespread interest.

Professor Robertson of the Edinburgh Royal Hospital was a confirmed Freudian, who believed that Freud had 'supplied the key which opens the doors of the mansions of the mind'.[84] As a natural consequence of his convictions, the Royal was among the most active centres of psychotherapy - and particularly of the Freudian psychoanalysis that was 'its most scientific and important variety'[85] - in Scotland in the 1920s. During 1921 Dr. O'Connell, an Assistant Physician at the institution, treated many patients by psychoanalysis,

and, in the following year, a Psychological Assistant Physician whose duties were almost entirely confined to psychological investigation and treatment was appointed. The results of the therapy, however, were mixed. While interesting and favourable results were obtained in cases of incipient or mild mental illness, the response of patients suffering from more severe or long-standing conditions was less encouraging. The evidence suggested that while psychoanalytic treatment was curative in the very early stages of illness, it did not seem to help those whose insanity was confirmed. In some cases, indeed, it appeared to be actually harmful, and aggravated rather than relieved the symptoms of patients in the acute phase of melancholia.[86] In the light of experience, Professor Robertson was anxious to avoid the exaggerated claims which had proved harmful to new treatments in the past, and he emphasised that patients must be carefully selected; those who had no insight into their condition and who were thus incapable of the co-operation with the doctor that the therapy required were unsuitable for psychoanalysis. But even though he recognised that few dramatic cures were to be expected Professor Robertson remained convinced that psychoanalysis provided an understanding of the patient's symptoms and mentality that was of the utmost value in general treatment.[87]

In general, however, orthodox psychoanalysis did not gain a very wide following among Scots psychiatrists. A hybrid form of psychotherapy, however, which was shorn of the more 'extreme' features of Freudian theory, was more popular. Professor Henderson was typical of many psychiatrists who had 'no particular axe to grind', and who were unwilling to ally themselves to any one school of psychotherapy. He had the greatest admiration for the work of the

psychoanalytic school, but was more than willing to assimilate concepts from non-Freudian sources to produce a 'bowdlerised' form of psychotherapy. He used all forms of psychotherapeutic techniques, including 'deep' psychoanalysis, but felt that a 'multi-lateral approach' was often more useful than the utilisation of an extremely specialised procedure.[88] This catholic approach was reflected in other institutions. Although specialised psychotherapy was employed in the Crichton Royal in the 1930s, it was as part of, or as an adjunct to, a much broader programme which incorporated the rational explanation of mental symptoms, re-education, suggestion and auto-suggestion, persuasion, encouragement and advice.[89] By such means, elements of specialised psychotherapy were assimilated into the more traditional non-physical treatments, and rigid dogmatism was rare.[90] This eclectic approach - which might be regarded as an example of the proverbial national talent for compromise - enabled Scots psychiatry to largely avoid the sectarianism which blighted it in other countries.

Psychotherapeutic concepts also held implications which reached outside psychiatry. Psychology also felt the impact of the main concepts of psychoanalysis, but psychologists were in general conservative. British psychology remained predominantly anti-Freudian; James Drever Snr., perhaps the most influential psychologist in Scotland during the period, was distinctly lukewarm in his response.[91] Psychoanalysis, however, may also have helped to pave the way for the entry of psychiatric social workers. Increased recognition of the importance of psychological, non-organic factors in the causation of mental illness stimulated interest in these external factors and thus in the social conditions of patients.[92] Even before the beginning of theoretical training for psychiatric social work, Edinburgh had taken

steps in this direction.[93] The psychiatric outpatient clinic at the Royal Infirmary, opened in 1925, had the services of a 'lady almoner and social worker' for domiciliary work,[94] and, by 1933, a social worker who investigated 'the environmental conditions and economic circumstances which may have contributed to ... breakdown',[95] was attached to the Royal Infirmary Clinic and Jordanburn Clinic. A social worker attached to Bangour Asylum was involved in the follow-up work with patients attending the clinic at the Royal Victoria Dispensary.[96] Psychoanalytic theory did not, by itself, create psychiatric social work but it did, by encouraging the psychiatrist's interest in the family life and background of patients, contribute to the climate in which its expansion took place.

The Scottish response to Freudian theory and practice, and to specialised psychotherapy in general, then, was cautious. In fact, it appeared that the public's reaction to it was more enthusiastic than the professionals'; Professor Henderson complained that the public was obsessed with psychoanalysis, and 'seem to feel that because our patients are not being psychoanalysed that nothing is being done for them'.[97] The psychiatric profession, though, generally held a more realistic view of the place of psychotherapy in the treatment of mental disorder. Nevertheless, the reverberations of the new ideas could be felt in the increased recognition of psychological factors in both mental and physical illnesses. They reinforced the concept of the body and mind as an intimately integrated unit, and tended to erode the barrier which separated them. The relationship between Scots psychiatry and Freudian psychoanalysis was, in most cases, a short-lived flirtation. The significance of mental factors in illness, however, was not lost sight of even when psychiatrists eagerly adopted

new physical methods of treatment.

(iv) Physical treatments

In the years following the war, a promising new treatment was developed for one of the great scourges of psychiatric medicine. General paralysis of the insane - the tertiary stage of syphilis - attacked the nerve cells and fibres of the brain, and led to dementia and paralysis.[98] In the first quarter of the twentieth century, it was responsible for a considerable proportion of all admissions to Scots asylums and among the chronic asylum population, there were many suffering from general paralysis. Some asylums had, since before 1914, treated the disease with derivatives of arsenic, with some success. The biggest breakthrough, though, came with the development of the Wagner-Jauregg innoculation. It involved the induction of malaria, which produced a rise in temperature and 'spikes' of fever, which apparently attacked the organisms which caused general paralysis. In 1923, Edinburgh Royal Hospital was one of the first British institutions to experiment with the method on a large scale. Professor Robertson was somewhat dubious of it at first; no treatment, he felt, could appear less hopeful than the expedient of imposing one disease upon another.[99] The results, though, were impressive. Most cases showed tangible improvement, while in others there was 'a complete transformation of the person'.[100] The method seemed to produce greater benefits than any which had previously been tried, and it came into widespread use in Scots asylums during the 1920s and 1930s.

Malarial innoculation, however, was not a problem-free procedure. Some forms of malaria were more virulent than others, and

there was a significant mortality rate of approximately 1:20.[101] The treatment became less of a leap in the dark, however, when it became apparent that fever produced in other ways was equally effective. By the early 1930s, Glasgow Royal Mental Hospital was experimenting with the production of fever by 'diathermy' - heating of the body tissues by means of an electric current.[102] At the Aberdeen Royal, patients with general paralysis and other conditions were treated by means of 'protein shock treatment', in which a foreign protein was introduced to produce rigor.[103] The common treatment for all syphilitic infections, arsenical injections, also continued to be used in conjunction with other treatments.[104]

The effect of this multi-pronged attack on general paralysis was striking. Remissions were more frequent and in some patients the disease was arrested to such an extent that they were able to return to their homes and jobs. Some, indeed, did not have to enter asylums at all but were treated, in the early stages of the disease, in general hospitals.[105] The proportion of admissions to asylums which were due to general paralysis fell significantly.[106] The impact, however, seemed to some to be most clearly shown in the drop in deaths from the disease, which fell dramatically in the inter-war period.[107] While the treatment of general paralysis certainly held dangers for the patient, these must be weighed against the beneficial effects of it, both upon the individual and upon institutions which were freed from having to deal with a mass of chronic illness, with consequent relief to the asylum accommodation.

Optimism was also encouraged in the mid-1930s when another new therapy was developed which seemed to offer hope for the alleviation of one of the most intractable problems in psychiatry. Schizophrenia,

or 'dementia praecox', usually became manifest during adolescence, and was generally believed to have a strong constitutional or hereditary component. It had proven largely unresponsive to treatment, and was responsible for approximately 60 per cent of the long-term and permanent population of Scots asylums.[108] A breakthrough in treatment was made when Sakel, a Viennese doctor, developed insulin coma therapy. The method, which involved using insulin to produce hypoglycaemic shock and coma,[109] seemed to yield encouraging results. It was introduced into Great Britain, and Edinburgh Royal Mental Hospital became one of the first institutions to experiment with it when H. Pullar Strecker (who had studied under Sakel) began to use it at Morningside in 1935.[110]

The method had major drawbacks, however. It was extremely time-consuming. A typical course of treatment involved the induction of approximately sixty comas, each of around an hour's duration;[111] it thus placed a heavy burden on medical and nursing staff. The results, too, were rather disappointing; while some schizophrenic patients showed some improvement, Professor Henderson found that experience did not substantiate some of the more optimistic reports of the therapy's adherents. In particular, while those in the more acute stages of the condition seemed to derive some benefit, the results among cases of long-standing schizophrenia were less than impressive.[112] Furthermore - though this did not necessarily invalidate it - the therapy was based on a mistaken premise; some years after it was introduced, it became apparent that whatever caused the effect, it was not hypoglycaemia.[113] Nevertheless, it was, by 1939, too early to form any final assessment of the method, and Scots asylums persevered with it.

A third major new form of treatment also became available.

Convulsive therapy, which was to become one of the most widely used and long-lasting of all physical treatments, was also introduced in the 1930s. Developed by Von Meduna in Budapest, it involved the use of cerebral stimulants to produce epileptic seizures. The convulsant drugs cardiazol - a synthetic derivative of camphor - and triazol were most commonly used in Scottish asylums. Cardizol, especially, was 'drastic' in its immediate effects, and the consent of a relative was required before it was administered.[114] However, drugs were gradually superseded by the use of electricity,in electro-convulsive therapy or 'E.C.T.', which was generally simpler and safer. It was, however, E.C.T. in its 'unmodified' form; muscle relaxants were not used in the 1930s, and the spasms produced during the therapy not infrequently resulted in fractures. The patient was also not anaesthetised. Convulsant therapy was, before the introduction of anaesthesia and muscle relaxants, a more unpleasant experience for the patient than it later became.[115]

While malarial innoculation, insulin coma therapy and convulsant therapy were the most important new physical treatments of the inter-war period, a variety of others were also used in the 1920s and 1930s. They included heliotherapy - treatment by sunlight - hydrotherapy - treatment by the external application of water - radiotherapy - treatment by X-rays - and the use of arc and mercury vapour lamps. Some of these treatments were relatively short-lived 'fringe' therapies, but they were indicative of a willingness on the part of many Scots psychiatrists to experiment with various methods. Equally, they were evidence of a continued belief that organic or physical factors played a major role in the causation of much mental disorder. The part played by organic factors in mental conditions

like general paralysis or encephalitis lethargia[116] was, of course, obvious. But there was also a conviction that bodily factors played a more subtle role in less serious mental or neurotic conditions. Thus, Dr. Easterbrook asserted that bodily ill-health was present in every case of mental illness - not always in the form of some gross pathological lesion of the bodily organs but in the form of generalised minor pathological stresses which affected the whole bodily economy.[117] It was to these minor stresses that heliotherapy and the other treatments described above were directed. They were not really intended to attack mental symptoms directly, but aimed to build up general health and well-being and thus, by implication, mental health.

As has already been suggested, it would be simplistic to depict the inter-war period as one polarised into two opposing camps, one adhering to a belief in the organic basis of mental illness and thus in physical methods of treatment and the other convinced of the primacy of psychological factors and therapies. Nevertheless, very real differences did exist. Professor Robertson continued to believe that the mind 'dominates everything',[118] and preferred to stress the importance of psychological factors in bodily illnesses rather than the significance of physical factors in mental illnesses. Dr. Angus MacNiven, the Physician-Superintendent of the Glasgow Royal Hospital, also believed that the bulk of cases of mental illness were 'psychogenetic' in origin.[119] Dr. Easterbrook, and Dr. Bruce of Perth District Asylum, on the other hand, emphasised the role of physical factors.[120] These different views held obvious implications for the therapeutic orientation of asylums; Professor Robertson's support of psychotherapy has already been described, while Dr. Easterbrook's belief in attacking mental illness via the bodily mechanisms was

reflected in the impressive facilities available for physical treatments at the Crichton Royal Institution. They could also be the cause of some tension. The General Board was keen to see a shift of emphasis at the Edinburgh Royal Hospital; following Professor Robertson's death in 1932, it urged the new Superintendent, David Henderson, to adopt physical therapies.[121]

These divergent opinions could never be fully reconciled. However, a sort of synthesis - similar to that between 'nature and nurture' which has already been described - did emerge. Psychiatrists generally agreed that mental derangement could follow many physical conditions, and that physical symptoms with a psychoneurotic base were prevalent. They also accepted that the investigation and treatment of mental disorder should always embrace the investigation and treatment of physical disorder. Extremist positions were rare. It was increasingly believed that body and mind could not be divorced and that pathological conditions and psychic stresses both frequently played a role in the causation of mental illness, the one acting upon the other. This dualism was, indeed, reflected in the combination of physical and psychological treatment that asylums offered. If, by the latter part of the 1930s, physical therapies were stressed, it is unsurprising. Its benefits were tangible and, as in the case of general paralysis, susceptible to measurement in a way which the more abstract effects of psychological treatment were not. Given the disparity between the concrete advances made through physical treatments and the somewhat inconclusive results of psychotherapy most Scottish psychiatrists tended to give a more prominent place to the former.

The history of psychotherapeutic and physical treatments in the

inter-war years highlights the pitfalls of characterising a period as one in which any one school of thought was dominant. Psychological and physical therapies were not mutually exclusive; even at the height of the interest in psychotherapy, new physical methods were embraced, and occupational therapy, a psychotherapeutic treatment, developed and expanded throughout the 1930s. In some cases, patients were suited to one form of treatment; psychotherapy was inappropriate for patients with general paralysis of the insane, while radical physical intervention was inappropriate for those suffering from minor neurosis. In many cases, however, both forms of treatment were applied at the same time, in the same place, by the same doctors and frequently to the same patients.

PART III

Towards a National Mental Health Service, 1939-60

Chapter 7 World War Two and the Birth of the National Health Service

(i) The mental health service in the war

(ii) A national mental health service?

(iii) The organisation and implementation of the new service

(i) The mental health service in the war

World War Two, like World War One, was a period of disruption and difficulty for the lunacy and mental deficiency services, and the problems caused by the requisition of mental institutions, the displacement of patients, and staff and other shortages will be described. However, the chapter will not focus entirely, or even primarily, upon these physical effects. Even when the distress caused by the war was at its height, simultaneously steps were being taken which would result in the creation of the National Health Service. This chapter also discusses the way in which the broad outline of the prospective service was moulded, refined and - in the case of the mental health service - radically altered during the war years to crystallise in legislation of profound significance.

Two major differences between the World Wars were to have a significant impact on the course of wartime and post-war social policy. The first was the extent of the warning of the impending conflagration; whereas the Great War had arrived almost as a bolt from the blue, the build-up to the Second World War was almost agonisingly protracted. The second was the advances which had been made in military technology, and its implications for civilian casualties; in World War One, the vast majority of deaths had been among servicemen, but the increased potential for aerial attack meant that in any subsequent confrontation a heavy toll would be taken of non-combatants. These factors combined to make it imperative both to try and reduce loss of life by moving people away from the likely target areas, and to provide a service capable of dealing with the civilian casualties which would inevitably occur; and the considerable preparation which took place before the war was directed towards these twin aims. It

began in earnest in the spring of 1938, when the Department of Health for Scotland started to survey the country's hospital resources. The momentum was maintained as it became apparent that 'peace in our time' had not been secured. Evacuation planning began, and a Scottish Advisory Committee on Evacuation was formed.[1]

These preparations received their acid test when, in the first three days of September 1939, over 100,000 children were evacuated from the most vulnerable areas - Glasgow, Edinburgh, Dundee, Clydebank and Rosyth.[2] A considerable number of 'private' evacuees, who made their own arrangements, also left. It was a massive and unprecedented operation and the relative smoothness with which it was accomplished was little short of an administrative miracle. The mentally defective, however, posed special problems. They could not easily be billeted with families and were therefore accommodated in residential schools improvised in large country houses.[3]

In the lull of late 1939 and early 1940, the evacuees' drift homeward caused further problems. They returned to an education system which, in many areas, had all but broken down. Many schools had been taken over for other purposes, and many teachers had been called up.[4] In some cases pupils were regrouped to conserve scarce accommodation, and in some instances - as in Edinburgh, where Slateford Occupation Centre had been taken over by the Auxiliary Fire Service - the mixing of low-grade defectives with other children caused problems.[5] The blackout also forced the closure of the clubs held in the evening for past pupils of special schools.[6]

Although, in the short term, evacuation caused stress and strain, many felt that, in the longer term, it had a beneficial effect. The mingling of the various classes that it entailed, it is

argued, resulted in a greater recognition of the poor conditions in which many of the urban working class lived, and thus to a desire to do something about it through the creation of a better health service. The classic case for this was propounded by Titmuss, who asserted that evacuation shattered the mutual ignorance of the social classes and thus had a major impact on post-war policy.[7] Gibson agreed that 'nothing was to change Scottish social attitudes so much as the first impact of evacuation'.[8] The possible consequences of evacuation were also recognised, surprisingly early, by some of those working 'on the ground'; Edinburgh Education Committee, for example, in 1939 and 1940 declared that evacuation was 'probably the greatest social experiment of our time', and felt that it had provided 'point and direction for a vigorous attack upon many social evils when the opportunity arises'.[9]

It is, however, doubtful whether the case for the positive impact of evacuation can be sustained in respect of the mentally disordered. It is, anyway, debatable whether familiarity does breed greater understanding or sympathy; the boarding-out system had a long tradition in Scotland but there is little concrete evidence that Scottish attitudes towards the mentally disordered were any more 'enlightened' than those of England, where it was almost unknown. Further, evacuation did not, in the case of the mentally disordered, actually produce much closer contact, though it may have changed the location of the mentally disordered person's isolation. Indeed, in some instances it resulted in greater separation, since many defective children who had previously attended day schools were, for some time at least, transferred to residential schools. Evacuation may have helped to create a wave of reformist opinion upon which the mentally disordered were carried along but, with the exception of the child

guidance service, there is little evidence that the mental health service profited directly from the experience.

The war had a mixed impact on the child guidance service. The prevailing adverse conditions, especially the shortage of staff, certainly slowed down its development but it did not completely halt it. Indeed, the general disruption of family life, and evacuation in particular, seemed to focus the official mind on the needs of children with educational, behavioural and emotional problems. One of the most notable developments in child guidance during the period was the direct result of the dislocation caused by the war when, in 1941, the Education Authority in Glasgow opened in Nerston the first residential child guidance clinic in Scotland in order to deal with evacuees in difficulty.[10] In the following year, a report by the Director of Education in Glasgow on delinquency among schoolchildren gave an added impetus to the better co-ordination of the voluntary and statutory child guidance sectors in the city. The grants to the voluntary clinics at Notre Dame and the University were increased, resources in staff were pooled between the voluntary clinics and the Corporation service, and an agreement was made co-ordinating policy and allocating specific areas of the city to each clinic. The Corporation also opened three emergency clinics during the war.[11] In Edinburgh in 1942 the local authority health and education departments combined to establish a clinic with the full three-member child guidance team.[12] In the country as a whole, the number of psychologists employed by education authorities increased - Dumbartonshire, Fife, Lanarkshire and Aberdeen City were among those which appointed psychologists to their education staff during the war[13] - and the total number of clinics in operation grew to eighteen at the end of the war.[14]

In the hospital service, two inescapable conclusions had emerged from the pre-war surveys. The first was that, in the event of war, some form of central control or direction of the service would be necessary to ensure the best use of available resources. This was achieved by means of the Emergency Hospital Scheme, created and developed under powers contained in the 1939 Civil Defence Act. It made the Secretary of State responsible for ensuring that facilities would be available for the hospital treatment of casualties occurring from enemy attack. These facilities were organised on a regional basis; five E.H.S. regions, centred on the four cities and Inverness, were created, in each of which a medical officer from the Department of Health for Scotland worked closely with the local authorities and the Medical Officers of Health. Inclusion in the E.H.S. involved an obligation on the part of the hospital authority to keep a number of beds - either a specified number or the maximum possible - always vacant to receive casualties. In turn, the Government made a payment to the hospital authority, both for the beds occupied by scheme patients and for the unoccupied beds.[15] At the peak period of the Scheme, in late 1944, it included all the large local authority and voluntary general hospitals in the country and comprised some 40,000 beds.[16] Four of the larger mental hospitals and parts of two mental deficiency institutions were evacuated for use as Emergency Hospitals.[17]

The immediate pre-war investigations, however, had revealed that available resources, however efficiently organised, were insufficient to cope with the expected casualties. Better facilities were urgently required. The extent to which mental institutions fell below the standards expected of modern hospitals was reflected in the

fact that asylums which were included in the E.H.S. generally required structural alterations to prove acceptable kitchen and sanitary facilities.[18] Their medical facilities were also improved, and new operating theatres were provided at Gartloch, Larbert and Bangour.[19] The need for more beds, however, was imperative. Some were provided by the utilisation of hotels and large private houses. A substantial hospital building programme, which provided seven new general hospitals, was begun. The accommodation in existing hospitals was augmented by the addition of hutted annexes; huts were erected at Gartloch, Larbert, Lennox Castle and Bangour.[20] In the case of existing hospitals (and their hutted extensions) which were included in the E.H.S., the hospitals' functions were different but no change was made in their administration. But self-contained hutted hospitals, the seven Departmental hospitals, auxiliary hospitals and converted premises were all administered directly by the Department of Health, which therefore became a considerable hospital authority.

The increase in the number of beds under the E.H.S. meant that substantial numbers of extra staff were required. An Emergency Medical Service and a Civil Nursing Reserve were formed to supply additional doctors and nurses. The E.M.S. was intended to ensure that adequate specialist and other staff were available at the Emergency Hospitals. The members of the service included residential officers, visiting consultants and specialists and local general practitioners, who were all appointed and paid by the Department of Health. Members of the Civil Nursing Reserve were enrolled for whole or part-time service in Emergency Hospitals, at first-aid posts and with evacuees, and included mental nurses. The placement of C.N.R. members in hospitals was in the hands of Regional Nursing Officers, appointed by

the Department for each hospital district.[21]

While the Emergency Hospital Scheme was originally intended for the treatment of air-raid casualties, these did not materialise in the numbers which had been expected, and the scope of the scheme was widened. Special units were established at Emergency Hospitals for the treatment of conditions which were not the direct result of enemy attack - among them 'mental shock' and other mental disorders. Provision for civilian patients suffering from neurosis was made at special units in Bangour and Gartloch Asylums. No provision, however, was made in the E.H.S. for the treatment of psychosis; civilian patients with psychotic conditions had to be dealt with in mental hospitals in the ordinary way.[22]

The civilian mental health service did not immediately benefit from the new accommodation provided during the war. In the future, however, it would, since the hutted annexes would form permanent extensions when the institutions at which they were erected were returned to normal use. There were other ways, too, in which the E.H.S. proved to have a longer-term effect on the service. The experience the D.H.S. gained during the war strengthened the case for separate Scottish negotiations on a future national health service. The Department had itself run an E.H.S. since 1939, whereas the Ministry of Health in Whitehall had not. The Secretary of State could thus justifiably claim that he, rather than the Minister, should conduct the necessary consultations.

The E.H.S. umbrella also provided a point of contact between hospitals of different types, including mental institutions. Hospitals which had, in peacetime, existed side by side 'without the completeness and cohesion of a system'[23] were, for the first time,

linked together under the Scheme, which thus, to some extent at least, broke down the isolation of the different hospitals and 'decompartmentalised' the Scottish hospital service. In some instances, the contact provided between different types of patients was almost physical; Gogarburn Institution treated almost 9,000 service personnel as in-patients, and many thousands as out-patients, during its time as an Emergency Hospital, but throughout the war its mental deficiency population remained at around 500.[24] The 'transfer' system tended to do the same. It was a cardinal principle of the E.H.S. that specialised treatment should be secured at the earliest possible stage for patients who needed it, and transfers between general wards and special units - in the same, or other, hospitals - were developed on a scale unknown before the war.[25] The ready availability of specialised resources was acknowledged to be an essential feature of any comprehensive service, and the experience thus gained would, it was acknowledged, be valuable in framing future schemes. The Emergency Medical Service, too, was a form of 'trial run' for the future health service, since, through it, the medical profession experienced central direction and a salaried service. It may also have helped to breach the barrier between mental and general health, because psychiatrists were included in it alongside other specialists and general practitioners.

The division of the country into five regions for E.H.S. purposes also held implications for any future reorganisation, and seemed to many to provide the basis on which the post-war service must be developed. It was not an entirely new concept; a similar arrangement had been proposed before the war by the Cathcart Committee.[26] Crucially, though, the E.H.S. had shown that it was viable. In this,

as in other ways, the Scheme telescoped into a few years a wealth of experience and innovation which might otherwise have taken much longer, or, indeed, might never have happened at all. It had - with its central direction, co-ordination between different types of hospitals, regionalisation and ease of transfer - provided an approximate working model of what a future reorganised service might be like in action.

As in World War One, special arrangements were made for mentally disordered servicemen. Treatment was provided at military hospitals in Larbert, Dumfries and Carstairs,[27] and Kingseat Asylum, Aberdeen was requisitioned by the Admiralty for use as a naval psychiatric hospital.[28] As in the First World War, too, men from the forces who became mentally ill were divided into the pensionable - whose condition was attributable to, or aggravated by, military service - and the non-pensionable, whose condition was not; the Ministry of Pension's attitude to schizophrenic servicemen, the majority of whom were refused pensionable status, was the cause of some ill-feeling among patients and their relatives.[29] But the provisions made for mentally disordered servicemen were generally believed to be superior to those made in World War One, particularly in respect of prevention. More careful screening and selection - in which personality, intelligence and aptitude tests played an integral role - was employed to weed out, at an early stage, those who were unfit for service, and to assist in the efficient placement of personnel.[30] This utilisation, on a larger scale than ever before, of preventive psychiatry and psychology provided a new demonstration of their practical application and in the short-term at least it appeared to be effective in reducing the number of breakdowns among servicemen.[31]

Civilian patients in institutions undoubtedly suffered as a result of the war. In rare instances, the harm done was the direct result of enemy attack; in 1943, for example, Aberdeen Royal Mental Hospital was bombed during an air raid, and several wards, the nurses' home and the laundry were severely damaged.[32] In most cases, however, the impact of the war was less dramatic and more insidious. The patients displaced from institutions taken over for military and E.H.S. purposes had to be accommodated elsewhere, and were frequently scattered among institutions some distance away from their home. Some institutions also accommodated patients from overseas; twenty-six Polish ex-servicemen for example were admitted to the Murray Royal Asylum, Perth, in 1941.[33] As in World War One, the receiving institutions suffered considerable overcrowding as a result, and the pressure on their accommodation meant that new cases - if they were received at all - had to be discharged as soon as they had turned the corner of their illness. Patients also felt the effects of the general rationing and shortages.

Perhaps the most serious problem the service faced, however, was the shortage of nurses. It was not new, but was exacerbated by the loss of staff to war service, and, by 1944, had become so acute that a complete breakdown in the nursing service was threatened. The Government took various steps to try and improve the situation. The Minister of Labour and National Service established a National Advisory Council, with a Scottish Committee, to advise him on the recruitment and distribution of nurses. A register of those who had been nurses was compiled in an attempt to get those who were not currently employed as nurses back to the profession and help was given, where possible, from the Civil Nursing Reserve. Newly

qualified general trained nurses were directed to serve in mental hospitals.[34] 'Freezing' or 'standstill' orders were used to maintain existing staffing levels.[35] Despite all these efforts, however, the mental health service as a whole continued to suffer crippling staff shortages for the duration of the war.

The disruption of the service, however, did not signal the end of therapeutic innovations. As some doctors became disenchanted with insulin coma therapy and cardiazol, new treatments began to take their place in the therapeutic spectrum. 'Narco-analysis', in which patients were given drugs to help them recall memories, became popular during the war;[36] it had, at a time of acute staff shortages, the considerable advantage of cutting short the prolonged period of probing which orthodox psychotherapy often involved. Psychosurgery also began its relatively short-lived and controversial career during the war, and a considerable number of leucotomy operations were done - in general hospitals - in the early 1940s.[37] Leucotomy had, in its capacity to reduce patients to little more than vegetables, an unprecedented potentiality for disastrous side-effects. Nevertheless, radical as it was, this new treatment - like many others before it - was initially enthusiastically greeted by many psychiatrists, including Professor David Henderson, who in 1943 described the operation as 'one of the marvels of modern medical practice'.[38]

It is difficult to form an accurate picture of the overall impact of war on the mental health of the civilian population, since publication of detailed statistics was suspended during and after the war.[39] But, like World War One before it, the war did not appear to result in any significant increase in mental disorder among the public. While bombings, blackouts and evacuation may have contributed

to some cases of mental breakdown, the adverse effects of war again seemed to be offset by the positive impact of high wages, low unemployment and the 'psychological' benefits of solidarity; claims about the fibre of the race being toughened by the tempering effects of war were resurrected after an interval of more than two decades. It is, of course, difficult to separate reality from efforts to maintain or boost morale. The Department of Health, however, did find that, despite the myriad privations which might have been expected to increase mental disorder, such an increase had, at least during the first half of the war, not materialised.[40]

(ii) A national mental health service?

This chapter, for purposes of clarity, deals with the mental health service during the war and the introduction of the National Health Service in separate sections. It is, however, an artificial division for, in reality, the two themes cannot be separated. The investigations, negotiations and consultations which created the N.H.S. began in the middle of the war and continued throughout the height of the fighting and, as in the case of the E.H.S. and the E.M.S., the experience gained during the war affected the size and shape of the new service. The impact of the war and the lead-up to the N.H.S. were intertwined, in the case of lunacy and mental deficiency as in other areas of policy.

The Government's view of the broad outline of the future hospital service was given in the House of Commons on 9 October 1941. The Minister of Health's statement, which was made with the concurrence of the Secretary of State, laid down the general principles of the service. The Government intended, as soon as

possible after the war, to ensure that by means of a comprehensive hospital service, appropriate treatment would be readily available to everyone who needed it. It was proposed to lay on the major local authorities the duty of securing, in close co-operation with the voluntary agencies, the provision of the service by placing the partnership between the local authority and voluntary hospitals on a more regular footing. The new service was to be designed by reference to areas substantially larger than individual local authorities, however, in order to avoid wasteful duplication of accommodation and equipment. Specialised services were to be provided at selected centres within these wider areas, and arrangements would be made for a proper division of functions between hospitals in them. The Government envisaged the retention of the principle by which patients made a reasonable payment towards the cost of their treatment. In Scotland, the aims of future policy would be 'generally similar' though differences in the E.H.S. and in the methods of financing voluntary hospitals in Scotland were being considered.[41]

Thus, the Government was committed to a scheme of co-operation between existing hospitals to ensure that treatment should be available to all who needed it before the Beveridge Committee reported. It did so at the end of 1942. The report's proposals regarding social insurance were based on the premise that there would be action by the Government in other fields. Social security was only part of the provision necessary for an attack on the 'Five Giants',[42] and the success of the proposals depended on the fulfilment of three assumptions: Assumption 'B' was that there would be a comprehensive national health service, available to the whole population without examination of the contributions paid in any individual case.[43]

The Government, in the person of Sir John Anderson, announced its acceptance of 'Assumption B', and outlined the main planks of the new service, in the House of Commons in February 1943. The object would be to secure through a public, organised and regulated service, that everyone who wanted it could readily and easily obtain the complete range of medical advice and attention. The fullest use was to be made of existing resources, and public authorities, the voluntary sector and the medical profession would all have their part to play. Responsibility for securing a full and efficient service, though, would ultimately rest on the well-tried machinery of local government, working, very often, over larger areas. The professional interests of doctors, the position of voluntary hospitals and the patient's right to choose his own doctor would all be safeguarded. The service would not be coercive, and the Government had no intention of forcing the new service on those who wanted private treatment. In general, the scheme would 'pull together many of the loose strands ... and build up the ... service ... until it justifies ... the term comprehensive'.[44]

While he recognised that some questions - such as the terms and conditions of service for doctors - would have to be settled on a U.K.-wide basis, the Secretary of State was determined that separate Scottish consultations on the new service would take place. Historical reasons - different traditions and experiences - and demographic and geographic factors - the contrast, unparalleled in England, between the Highlands and Islands and the industrial belt - demanded it. Recent developments, particularly the D.H.S.'s experience of running the E.H.S., underlined the need.[45] To some extent, then, Scotland's necessity to go its own way was 'bluntly and successfully

asserted'.[46] This autonomy, however, had boundaries, albeit fluid and undefined ones. The extent to which Scotland's freedom of action was limited was particularly relevant in the case of the position of the mental health service in the wider scheme.

At an early stage, the Minister of Health had decided that the mental health service would, temporarily at least, be excluded from the new service.[47] It was very frankly admitted that the decision had been made on the grounds of expedience rather than principle; indeed, J.E. Pater of the Ministry conceded that 'on every ground of principle the ... services ought to be brought into the picture at the beginning as part of the comprehensive health service'.[48] Pragmatism, however, seemed to dictate otherwise. The rationale for the proposed exclusion of the service was its legal basis, which was, the Ministry believed, so out of date and chaotic that it could not conveniently be fitted into the rest of the health service. It might be possible to include it in the future if the Lunacy and Mental Deficiency Acts were radically amended, but in the short term the task of integration was felt to be too difficult to attempt.[49] Since it seemed unthinkable that the Scottish service could differ so fundamentally from the English one, it appeared that the mentally disordered in Scotland would also be omitted: as a D.H.S. minute acknowledged, somewhat plaintively, it appeared that Scotland 'must just accept the Ministry's view meantime'.[50]

In the months that followed, though, the policy came under increasing criticism from some of those most closely involved in the creation of the new service in Scotland. The local authority representatives and the D.H.S.'s medical advisors both felt that the service could not be 'comprehensive' in any real or desirable sense of

the term unless it embraced 'the complete mental health organisation'.[51] The increasing admission of voluntary patients and the development of psychiatric clinics in general hospitals meant that the mental health service could not, and should not, be regarded as something apart, and, they felt, the sooner that the service was properly integrated with the wider medical service the sooner would it be granted its proper status in the public mind .[52]

Howat and Henderson of the D.H.S. were increasingly uneasy about prospective exclusion, the latter admitting that 'the more I look at it the more I dislike the proposal to exclude the lunacy and mental deficiency services from the scope of the new national health service'.[53] Both recognised the validity of the arguments against inclusion and did not underestimate the formidable problems that the integration of the mental health service would pose. They were, nevertheless, convinced that it would have to be done. The exclusion of the services would cause organisational difficulties, with one administrative area for general health purposes and another for lunacy and mental deficiency, and would make the necessary expansion of psychiatric services in general hospitals more difficult. Above all, it would fly in the face of all the efforts which had been made to convince the public that mental disease was just another manifestation of ill-health and not 'a special thing', and would therefore perpetuate the stigma attached to it.[54] Significantly, this stance was backed by the General Board, whose Chairman, Sir John Jeffrey, encouraged Henderson with the succinct exhortation 'more power to your elbow'.[55]

In the spring of 1943, then, the D.H.S., and Howat and Henderson in particular, began to put pressure on the Ministry to

reconsider. It was suggested, too, that since the legal basis of the service seemed to be a barrier to integration, the suspended Russell Committee on the Scottish Lunacy and Mental Deficiency Laws might be revived to continue its review of it,but the response was initially disappointing; the proposed reactivation of the Russell Committee was turned down,[56] and Pater just reiterated London's attitude. A change, however, was soon apparent. Whereas in April 1943 the Minister had, in the House, curtly dismissed calls for a rethink, a month later he promised that the question of including the mental health service in the scheme would receive full consideration.[57] By the summer, a definite shift was discernible, and the Minister concluded that the difficult task of integration must be attempted.[58] The Secretary of State tacitly concurred.[59] It is not clear what role pressure from the Department, and other Scottish interests, played in this retreat; it may be significant that only a few days before announcing the re-opening of the question, the Ministry had received strong representations from Henderson.[60] However, pressure from the medical profession was apparently the decisive factor as the Minister gave as the reason for the change the views of the Representative Committee of the British Medical Association.[61] Later in 1943, the Russell Committee resumed its deliberations; although its report, which was finally issued in 1946, came too late to directly affect the shape of the N.H.S. and, in any case, confined itself to a general acceptance of the principle of integration,[62] the Committee's reactivation was further evidence of the desire to incorporate the mental health service into the new scheme.

This was undoubtedly a major shift of policy. However, the position of the mental health service within the prospective N.H.S.

still seemed a little precarious; as late as July 1944, Baile Hunter, a Scottish local authority representative, felt compelled to warn that any suggestion of separating the mental and general health services would be resisted.[63] It does not appear, though, to have been seriously questioned again. The decision to include the service, like the previous policy to exclude it, has received little attention in even the most exhaustive histories of the N.H.S. but it was, nevertheless, a milestone. It seems likely that if the original policy had been adhered to, the mental health service would more than ever have been a poor relation to the general health service. But while the broad policy to be followed was now clear, much work remained to be done on the details of integration.

Opinions differed as to how difficult the task would be. Sir John Jeffrey believed that the service could be 'fitted into' the N.H.S. without too many complications, but the Department of Health felt that the problems it presented might mean it would have to lag a little behind the inauguration of the new machinery.[64] The terminology used, though, was significant. The N.H.S. would, in the Minister's phrase, 'contain' the mental health service.[65]

Valuable time had already been lost. While Scottish mental health interests - principally the General Board - were included in later consultations with the Secretary of State, the previous exclusion of the service meant that they were not in at the start. It might be overstating the case to imply that the mental health service was tacked on to the N.H.S., since when the decision to include it was taken much negotiation on the shape of the new service generally still lay ahead. Nevertheless, the mental health service had to some extent to be tailored to fit the wider picture.

The area of administration for the new hospital service was the subject of much controversy. At either extreme lay those who felt that the existing areas were sacrosanct, and those who thought that the existing local government system could be ridden over rough-shod. In the middle ground, though, there was a growing belief that some wider administrative area was needed. While cities would find it relatively easy to secure adequate provision for people in their area, the majority of local authorities, particularly the sparsely populated and poor ones, would find it impossible to do so with their much more limited resources. Three main possibilities emerged in discussion. The first - that administration should be centralised and responsibility lie with a single central authority - was dismissed on the grounds that the service, in principle, fell within the proper ambit of local government.[66] The second - that the existing local authorities enter into some form of combination for hospital purposes - was favoured by the local authority representatives.[67] Some sort of regional advisory machinery, based, perhaps, on the five E.H.S. regions, could co-ordinate it. The Scottish representatives of the British Medical Association, however, felt this did not go far enough, and believed the regional, rather than local, machinery should have the executive power.[68]

The hostile attitude of many doctors towards local authorities was, indeed, the cause of some difficulty. Col. T.D. Inch of the B.M.A. Scottish Committee reported that the profession was 'absolutely adamant' that it would not become part of a service under local authority control.[69] Some doctors felt that local authorities were already hopelessly overburdened. Others feared they might suffer from the play of local politics and prejudices. Still others seemed

motivated primarily by snobbery, believing that local authority work did not attract 'the best minds' or the 'right sort' of men.[70] It seemed that nothing could overcome the doctors' antipathy to becoming, as they saw it, part of the local government machine.

The Secretary of State was determined that voluntary hospitals would be 'set into the mosaic of the new State Medical Service'.[71] They, however, were apprehensive about their future under a comprehensive service, fearing that it might be used to 'wreck and confiscate' the voluntary hospital sector.[72] Their misgivings focused particularly on the implications of the Beveridge insurance proposals (or what seemed their implications at the time); if the Beveridge stamp was all-inclusive, 'what logical or reasonable basis remained for an appeal to the charitable public?'[73] The possibility that the duty of running the hospital service would be placed on joint committees of local authorities, on which the voluntary hospitals would not be represented, also perturbed them, and they were not consoled by the prospect of inclusion in the advisory and co-ordinating machinery.

Some of the threads were drawn together by the Hetherington Committee, which had been appointed to try and solve the administrative problems which might arise in Scotland when the Government implemented its hospital policy; since, at the time of its appointment, in January 1942, the policy envisaged did not include the mental health service, its report of October 1943 did not deal with the service in any depth. For the hospital service in general, it proposed the creation of wider administrative areas of joint committees of the representatives of several local authorities, and recommended the development and co-ordination of the service on a

regional basis, proposing that Scotland should be divided for the purpose into the now familiar five E.H.S. areas. It had little to say about the mental health service but assumed that, given local authorities' experience in providing and administering mental hospitals, they would continue to carry their existing responsibilities for treatment.[74]

Reception of the report was somewhat predictable. Its recommendations on executive joint committees and advisory regional councils were seen by those who opposed local authority control of the new service as merely perpetuating its defects. The British Hospitals' Association felt that the councils would have no real influence, and would reduce the role of the voluntary hospital sector to that of a junior or sleeping partner.[75] The B.M.A. felt that the Committee's terms of reference had been too narrow, and that its findings were therefore similarly limited.[76] Despite the cool reception the report received, however, many of its recommendations were included in the subsequent Government proposals.

The current state of Government thinking was encapsulated in the White Paper of February 1944. It reiterated the basic principles of the new service - it was to be universally available, but participation in it would be optional for patients, doctors and voluntary hospitals, it was to be comprehensive, and it would provide for a free choice of doctor.[77] Significantly, in the wake of the Hetherington Report, the service would, with minor exceptions, be free of charge.[78] Administratively, the Secretary of State would be responsible to Parliament for the general policy and central planning of the entire service, and would be directly responsible for the detailed planning and provision of the G.P. service, which would be

based on group practice, operating from health centres provided by the D.H.S., and the service would be financed from central funds. The hospital service would be provided by Joint Hospital Boards formed by the grouping together of the existing major health authorities, while the service would be co-ordinated on a regional basis by the D.H.S. with the assistance of five Regional Hospital Advisory Councils. Unlike the J.H.B.s, the R.H.A.C.s would have voluntary hospital representatives. Responsibility for the non-hospital services would remain a function of the existing major health authorities.[79] The inclusion of the mental health service would be difficult, but would have to be done if the Government's aim 'to reduce the distinctions drawn between mental ... and physical ill-health' was to be accomplished.[80]

The White Paper was put forward as a basis for constructive criticism, but the criticism it received was largely destructive. Critics conjured up an array of bogeymen and the White Paper was seen by some as a Trojan horse concealing some sinister intent. There was, in particular, controversy about whether freedoms - those of the voluntary hospitals to retain their identity, of patients to choose their own doctor, of the doctor to stay out, and to practise his profession according to his own judgement,could be maintained under the proposals.[81] Reconciling the doctors' reluctance to work with local authorities, the voluntary hospitals' apprehensions for their future, the desire of local authorities not to part with their health functions,and the needs of individual citizens, seemed almost as far away as ever. The seemingly interminable round of discussions began again.

Consultations regarding the N.H.S. mental health

service took place following the publication of the White Paper. Despite the reception it had received, they were conducted on the basis of the tripartite structure set out in it. The G.P. service would, of course, be available to all, regardless of whether they suffered from mental or physical illness. The function of securing an adequate institutional service, and responsibility for psychiatric out-patient clinics in general hospitals, would devolve on the J.H.B.s. The proper place of some domiciliary functions, though, was less clear cut. Should the duty of supervising boarded-out lunatics and defectives rest with the new J.H.B.s or the existing local authorities? Placing it on J.H.B.s would be a departure from the White Paper's basic principles, but so few local authorities would be able to employ psychiatric social workers to carry it out that the D.H.S. felt it should be a J.H.B. function.[82] Similar questions arose in the case of ascertaining defectives who were beyond the scope of education authorities, and the Department had similar views on it.[83] Most vexed of all was the question of whether the new Boards should be required to set up special mental health committees. At a time when mental health seemed, at last, about to take its proper place in the wider health service, it seemed to be tempting fate to do anything that might contribute to the schism between mental and general health. It was, on the other hand, undeniable that the service presented singular problems. Sir John Jeffrey supported the idea of special committees, fearing that otherwise mental health might be disregarded. Local authority representatives, though, resented any coercion and felt that the question should be left to the discretion of J.H.B.s.[84]

The proposed establishment of a comprehensive service held implications for the future position of the General Board, particularly

in respect of its control over the institutional service. There was a general consensus that since the mentally disordered were in a special position regarding restrictions on their personal freedom, the continuation of an independent body to safeguard their interests was necessary. But the need to maintain an effective liberty-of the-subject authority had to be reconciled with the demands of an integrated hospital service. The most obvious solution seemed to be that which had been rejected a few years earlier - for the Board to be retained for its liberty-of-the-subject functions, but for its other functions to be transferred to the D.H.S. - and this was, in fact, the implication of following the English proposals, which envisaged the transfer of the English Board's administrative functions to the Ministry of Health, but the Board's continuance for liberty-of-the-subject questions.[85]

However, the objections which had prevented such a change in Scotland in the late 1930s had not lost their force in the interim. How could the Board's functions be divided without creating either an artificial and unworkable schism between closely related functions or duplicate or parallel machinery? In England, a compromise seemed to have been found. Both sets of functions would in practice be dealt with by the same people; that is, the English Board would retain its separate existence for liberty-of-the-subject functions, but its personnel would act in their capacity as officers of the Ministry of Health when dealing with other matters.[86] This was not such a novel prospect in England, where all the Board's members had, since the Mental Treatment Act 1930, been full-time civil servants. But in Scotland, where no such change had been made, the arrangement would be a new departure and, the General Board was convinced, an unfortunate

one. Sir John Jeffrey not only doubted whether a Board composed entirely of D.H.S. officers would have any real independence, but felt that such an arrangement was impossible. The Scottish Board, unlike its English equivalent, had part-time members with no departmental affiliation, and it was very difficult to see how they could be absorbed into a departmental organisation; the legal member, for example, was a Sheriff Principal. On grounds of both the principle and practicality, therefore, the Scottish Board felt that the English model was inappropriate for Scotland.[87]

The Scottish consultations, however, were overtaken by events on the wider political stage. The Labour Party had been swept to power in the 1945 General Election, and Aneurin Bevan had become Minister of Health. Officially, the Party was committed to a local authority-run service but, by late 1945, it appeared that Bevan intended to take all hospitals, including voluntary ones, into State ownership; in effect, to nationalise the hospital service.[88] By January 1946 a confidential D.H.S. memorandum based on the new proposals had been drawn up. It provided that the Secretary of State would assume direct responsibility for the hospital and specialist services, which would be taken over by him, and their buildings and other assets vested in him. He would, however, delegate the bulk of the administration to new regional and local bodies acting on his behalf. Local clinic, domiciliary and welfare services would be a direct function of local health authorities, and the administrative machinery for the services was to be the normal machinery of local government. New local executive machinery would be set up for the general practitioner service. The General Board of Control's administrative functions would be absorbed by the Secretary of State.[89]

This, with only minor modifications, was the basis of the National Health Service.

The 1947 National Health Service (Scotland) Act placed mental health squarely in the mainstream of the new service. Under it, the Secretary of State was required to promote the establishment of a comprehensive health service designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness, which, the Act made clear, included mental disorder.[90] The broad outline of the service has already been described with reference to the memorandum of January. The G.P. service was to be administered by new Executive Councils, established in each of the twenty-one counties and four cities, and consisting of members appointed by the Secretary of State and the local authorities, as well as by the professions concerned. The hospital service would be based on the five E.H.S. regions, in each of which would be established a two-tier administrative and executive structure, while the local authorities would retain the domiciliary services, with new functions.

The 1947 Act specially provided that on Regional Hospital Boards, established in each Hospital Region as the Secretary of State's agents for the administration of the hospital and specialist services, at least two members were to be persons with experience in the mental health service.[91] The R.H.B. would plan, provide and integrate the services in its area, control directly any service organised on a regional basis, and appoint specialists and other senior medical staff. Regional Boards were required to prepare schemes for grouping hospitals in their region under Boards of Management. These Boards were to control and manage individual hospitals,

or groups of hospitals within manageable distance of one another, on behalf of the R.H.B., and the day-to-day work of running the hospital(s) would devolve on them. B.O.M. members were to be appointed by the R.H.B.[92]

The Act gave local authorities important new functions in respect of preventive and promotive work. Section 27 enabled L.H.A.s to make arrangements for the purposes of the prevention of illness, the care of those suffering from illness or mental deficiency, and for after-care. While these were discretionary powers, it meant that L.H.A.s would, for example, be able to provide informal supervision for mental defectives living in the community. Local authorities' duties towards the mentally defective were also extended. While local authorities had previously been obliged to deal with defectives by placing them in an institution or under guardianship, section 51 of the 1947 Act gave them a new duty to secure suitable training and occupation for juvenile defectives excluded from special schools, and for defectives over sixteen. The local authority did not necessarily have to provide it itself - the Act made provision for L.H.A.s to utilise the services of voluntary organisations on an agency basis[93] - but the responsibility for ensuring that it was available was placed firmly on the L.H.A. Each L.H.A. was required to draw up a scheme for the discharge of its mental health and other functions. These schemes had to provide for the establishment of a health committee to which the L.H.A.s' mental health functions would stand referred, but, despite the General Board's advocacy of them, the establishment of mental health sub-committees was not made mandatory.[94]

The provisions of the Act relating to the General Board reflected, on the one hand, the policy that the treatment of mental

disorder should be regarded as an integral part of general health service provision and, on the other, the need to retain adequate liberty-of-the-subject safeguards. The Board's functions in respect of the organisation and control of the institutional service were transferred to the Secretary of State although, since the Secretary of State was required to consult the Board in the performance of his mental health functions, the Board would continue to play an advisory role. The Board retained its functions relating to the liberty-of-the-subject and the interests and welfare of patients,[95] the supervision of mental hospitals and mental deficiency institutions not vested in the Secretary of State, and (the most important of its traditional functions), the inspection of all mental hospitals and mental deficiency institutions.[96] The Board retained its status as an independent statutory body for these purposes.

This reorganisation had implications for the Board's constitution. All the officers of the Board, other than the Deputy Medical Commissioners and the Secretary, were transferred to and became officers of the Secretary of State; the Deputy Medical Commissioners retained their position as officers of the Board but they, and the Secretary, would also hold appointments as officers of the Secretary of State. Of the Board members, the Medical Commissioners, though retaining Board membership, would also hold simultaneous appointments as officers of the Secretary of State, but the independent, part-time non-medical Board members, including the legal member, retained their existing position.

This somewhat complex structure was intended to obviate the necessity to make fine distinctions between institutional functions, which had been transferred to the Secretary of State, and those

functions relating to the liberty and interests of the individual which the Board retained. The Medical Commissioners would (as officers of the Secretary of State) deal with institutional matters and (as Board members) deal with liberty and welfare questions; the same people - wearing different 'hats' - would therefore be concerned with both types of function. The problems identified at the consúltative stage - the impossibility of absorbing all Board members into a Departmental structure, and the doubtful independence of a Board composed wholly of Departmental officials - had been avoided by the retention of independent Board members who, not being officers of the Secretary of State, would participate only in liberty-of-the-subject questions.[97]

The Act also made a number of minor but nonetheless significant enactments and amendments relating to mental health. One of these concerned terminology. The vast majority of institutions for the mentally ill had previously had the statutory designation of 'asylum',[98] but section 79 provided that they would henceforward be termed 'hospitals' in all enactments and documents; the Lunacy Acts were also amended to that effect. It was statutory recognition that although mental hospitals dealt with a particular group of patients, they were nevertheless hospitals whose primary function was curative. The Act also transferred powers previously discharged under Poor Law machinery; the Inspector of Poor's responsibility for making the necessary arrangemnets for compulsory admission to hospitals or guardianship was transferred to a Duly Authorised Officer of the L.H.A. Boards of Management were given powers to direct the discharge of lunatics, and, in view of the service's imminent absorption into the new regional structure, the whole of the Lunacy Districts

(Scotland) Act 1887 was repealed.[99] These provisions, and the Act as a whole, were to come into force on the appointed day of 5 July 1948.

The National Assistance Act 1948 also gave local authorities important new functions. Section 29 empowered them to make arrangements for promoting the welfare of persons 'substantially and permanently' handicapped by illness, injury or congenital deformity. It therefore authorised the provision of a fairly broad range of services for the mentally handicapped, and the Act suggested that they might include hostels and workshops. These powers were, once again, discretionary (although the Secretary of State was empowered to make them mandatory), but where welfare services were provided they were to be available to all who needed them, irrespective of economic status. The provisions would also come into operation on 5 July 1948.

While local authorities lost their hospitals, then, they were given extended powers to provide non-hospital services for the mentally disordered. Under the N.H.S. Act, they could provide community services with a medical flavour, and under the National Assistance Act they were enabled to provide more purely social services. It appeared that, under both Acts, local authorities had been given adequate powers to provide most of the services necessary for the development of a comprehensive community mental health service.

An important corollary of the new legislation was the final repeal of the Poor Law, which had, for more than a century, had such an intimate association with the lunacy service. While legislation in the inter-war period had gone some way towards separating the mental health service from it, the National Assistance Act was the decree absolute. Before it, the majority of the mentally ill had still been 'pauper lunatics', paid for by local authorities which had

Table 7:1 The Regional Organisation of the Hospital Service, 1947

THE NORTHERN HOSPITAL REGION	The Counties of Caithness, Inverness, Nairn, Ross and Cromarty, and Sutherland (including all the burghs therein)
THE NORTH-EASTERN HOSPITAL REGION	The County of the City of Aberdeen. The Counties of Aberdeen, Banff, Kincardine, Moray, Orkney and Zetland (including all the burghs therein)
THE EASTERN HOSPITAL REGION	The County of the City of Dundee. The Counties of Angus, Kinross and Perth (including all the burghs therein)
THE SOUTH-EASTERN HOSPITAL REGION	The County of the City of Edinburgh. The Counties of Berwick, East Lothian, Fife, Midlothian, Peebles, Roxburgh, Selkirk, and West Lothian (including all the burghs therein)
THE WESTERN HOSPITAL REGION	The County of the City of Glasgow. The Counties of Argyll, Ayr, Bute, Clackmannan, Dumfries, Dunbarton, Kirkcudbright, Lanark, Renfrew, Stirling, and Wigtown (including all the burghs therein)

Source: Report of the Department of Health for Scotland for the year 1947, p. 31

powers to recover from responsible relatives all or part of the cost of maintenance; this was now abolished. Twenty of the existing fifty-six Poor Law institutions were transferred to the Secretary of State for use as hospitals, while the remainder stayed under local authority control.[100] There were, just prior to the appointed day, still 196 mental defectives and 718 lunatics (in lunatic wards), in the institutions.[101] The lunatics were subsequently taken over by the hospital service and, since some of the institutions in which there were lunatic wards did not transfer, accommodation had gradually to be found for the patients in mental hospitals. The mental defectives, who were accommodated in the institutions under guardianship, remained a local authority responsibility.[102] Pauper lunacy, both the name and the thing, had, with all its stigmatising connotations, finally disappeared.

(iii) The organisation and implementation of the new service

While the approximate area of each hospital region was known, the actual areas were only settled following the Act and consultations between the Secretary of State and local health authorities. The areas of the five Hospital Regions are shown in Table 7:1. Not surprisingly, the massive Western Hospital Region, centred on Glasgow, dwarfed all the others in terms of population and resources. In terms of mental hospital beds, it was almost three times as large as the next largest region, the South-Eastern, and was more than ten times the size of the Northern Region. The differences in the number of mental deficiency beds is equally striking. Indeed, the Western Region's total institutional accommodation for the mentally disordered was, at 14, 845 beds, greater than that of the other four regions

Table 7:2 Number and Distribution of N.H.S. Beds, 1948

Region	Number of Beds		Total
	Mental Hospital	Mental Deficiency	
Northern	1,082	-	1,082
North-Eastern	2,374	32	2,406
Eastern	2,582	350	2,932
South-Eastern	4,152	747	4,899
Western	11,775	3,070	14,845

Source: Report of the Department of Health for Scotland for the Year 1948, p. 27

combined. A breakdown of the accommodation available in the five regions is given in Table 7:2.

The Chairmen of the Regional Boards were chosen first, so that they could get on with the preliminary work. By December 1947, a line-up of Sir Alexander McGregor (Western Region), Dr. J.R.C. Greenlees (S.E. Region), Treasurer William Hughes (E. Region), Dr. May Baird (N.E. Region) and Mr. Donald Macpherson (N. Region) had been picked.[103] The next task was to appoint the R.H.B. members, and the procedure was not without problems. It was not easy to find people of the right quality who had sufficient time to discharge their duties. Further, although it was made clear that members would be chosen for the contribution they could make as individuals, the sheer number and variety of interests which felt that they had a right to be represented on R.H.B.s was almost bound to leave some feeling under-represented. Strangely, given the express provision of the Act, mental health interests did not appear to be at the forefront of the Secretary's mind during the appointment process, since he originally omitted to consult the Scottish Division of the Royal Medico-Psychological Society (the professional organisation for psychiatrists) on R.H.B. membership.[104] One hundred and twenty-five members were eventually selected; the number on each Board - which was fixed by the Schedule to the N.H.S. (Constitution of R.H.B.s) (Scotland) Order 1947 - varied between eighteen and thirty-three. As well as people associated with the universities and voluntary hospitals, doctors (both specialists and G.P.s), L.H.A. members and several nurses were also appointed;[105] eminent psychiatrists, Professor Sir David Henderson and Dr. Angus McNiven, were to serve on the S.E.R.H.B. and the W.R.H.B. respectively.[106]

R.H.B.s had, by 1948, grouped hospitals under eighty-four Boards of Management, the smallest, in Arran, for two hospitals and twenty beds, the largest, in Glasgow, for six hospitals and over 3,000 beds.[107] In the case of mental institutions, the arrangements made followed one of three models. The D.H.S. memorandum of January 1946 had suggested that large mental hospitals should have separate management committees and in some cases - as in the instance of the Crichton Royal Mental Hospital - the B.O.M. was to manage a single hospital.[108] In many cases, though, all the mental hospitals in an area were grouped under a single Board, as in Dundee, Aberdeen and Perthshire, where the mental and general hospitals were under separate Boards.[109] The third possibility was for all hospitals - mental and general - in an area to be grouped under a single Board. This happened in Inverness, where Craig Dunain Mental Hospital was associated with the local general hospitals[110] and in Banff, where Ladysbridge Hospital became part of the Lower Banffshire Hospitals Board.[111] It would have been impractical to group all the hospitals in a city under one Board of Management, and some sort of separation was necessary there. It is significant, however, that in so many instances, the R.H.B.s choose to group mental hospitals together as a 'natural' hospital unit, rather than with general hospitals in the locality.[112]

Regional Hospital Boards began their task of appointing B.O.M. members. They were to be chosen after consultations with L.H.A.s, Executive Councils, senior medical staff and other interested individuals and parties, though, unlike R.H.B.s, no special provision was made for mental health interests. Dual R.H.B./B.O.M. membership, though not expressly forbidden, was not encouraged. The primary

qualification for B.O.M. membership was an interest in hospitals and the knowledge and experience to contribute to the Board's work. The Boards which were appointed comprised a variety of interests, including doctors, L.H.A. members and former voluntary hospital managers.[113] In some instances, a degree of continuity was maintained; when the Murray Royal Mental Hospital and Murthly Mental Hospital in Perth were united under a single B.O.M., for example, some of the former members of the separate Boards were appointed to the new B.O.M.[114] There were variations in the size of the new Boards - the largest had twenty-seven members, the smallest five - but the usual number was between fifteen and twenty.[115]

As the date for the introduction of the new service approached, however, some Royal asylums continued to view the prospect with some trepidation. Their attitude mirrored the feelings of voluntary hsopitals in general and Dr. Chambers, Physician-Superintendent of the Murray Royal Asylum, voiced the fears of many in the voluntary sector when, in 1946, he admitted awaiting the inception of the N.H.S. with some apprehension. He did not, he maintained, object to the concept of the service, but feared the 'degree of force, or violence' with which it might be implemented.[116] While a measure of co-ordination or regulation might be tolerable, or even desirable, Dr. Chambers dreaded regimentation or strict 'regionalisation' of the service.[117] Above all, he feared the loss of the Asylum's identity. Royal asylums had always jealously guarded their position of independence, even superiority, and had previously managed to resist much encroachment upon it. But it now appeared that the traditions and special character of the Royal asylums might be 'swept away and submerged' into the common pool.[118] Even those Royal asylum superintendents who

did not entirely share Dr. Chambers' views seemed to regard the N.H.S. as a leap in the dark or, as Professor Henderson put it, 'a large social experiment'.[119]

Some Royal asylums, therefore, were reluctant to co-operate with transfer. The governing body of the Murray Royal Asylum tried to avoid it by claiming that since the hospital did not receive rate-aided patients, it was 'carried on for profit' and was therefore not transferable. The D.H.S., however, rejected this argument.[120] Not all Royal asylums adopted a negative stance, and some were more than willing to co-operate; Glasgow Royal, in its reply to the intimation of transfer, declared that it would be pleased to render any assistance it could.[121] Whatever their views, however, Royal asylums were conscious that a chapter in their history was ending, and it was reflected in the frequency with which their annual reports of the period included potted histories of the institutions. All seven were duly transferred to the Secretary of State on the appointed day.

The transfer of another type of institution raised particularly difficult questions which required sensitive handling. Roman Catholic mental deficiency institutions were originally to be transferred since the alternative - whereby most of the institutions' income would derive from contractual payments made in respect of N.H.S. patients, yet the institutions would remain independent of any control - was felt to be unacceptable. In the end, however, other considerations - respect for religious freedom and, perhaps, a desire not to alienate an influential group - won. The Secretary of State decided that the transfer of the accommodation would not be required, and all the R.C. mental deficiency institutions were disclaimed.[122]

On 5 July 1948, then, all the hospitals in Scotland - with a

few exceptions like the R.C. mental deficiency institutions - passed into State ownership.[123] In all, some 425 hospitals, with accommodation for over 63,000 patients, were transferred to the Secretary of State; just over half of those transferred had belonged to local authorities or the D.H.S., and just under half had been voluntary hospitals. A little over one-third were mental institutions; approximately 28 per cent were mental hospitals, and 7 per cent were mental deficiency institutions.[124] At the time of transfer, the service was at a low ebb. Building restrictions were affecting the whole of the hospital service. Some of the accommodation which had been used for military purposes during the war had not been returned, and many mental institutions were overcrowded. There was an acute shortage of nursing and domestic staff; the number of nurses had actually fallen since the war because of the resignations of women who had taken up or resumed their duties during the war.[125] Many mental institutions, then, passed to the Regional Boards with an unwelcome legacy of scarcity and difficulty. It was an inauspicious start.

There were, however, grounds for optimism. The State ownership of mental institutions held out the promise of increased financial resources, and of their more equitable distribution. It also appeared likely that the nationalisation of the service, and its regional organisation, would, as some voluntary hospitals feared, tend to erode the differentials which had previously existed between mental institutions; but the hope was that it would result in more uniformly high standards. It seemed, too, that the new health and welfare functions of local authorities would result in improved amenities for the mentally disordered who lived in the community. The possible 'psychological' effects of the new service were difficult to predict,

but the advent of a 'free' N.H.S. and the abolition of the Poor Law might improve the public conception of mental disorder, and lessen the stigma attached to it. But while the National Health Service Act was the beginning of an era in the mental health service, it was only the beginning. Time and experience would prove whether these expectations were justified.

(i) The 1945 Act

(ii) Reconnaissance and response

(iii) Implementation and further investigation

(iv) Junior occupation centres

(v) The child guidance service

(i) The 1945 Act

In discussing the development of special education for the mentally handicapped in the post-war years, this chapter examines the progress and the problems of the service, the ways in which they were highlighted by investigation, and the extent to which promise became performance. The seeds of post-war development, however, were sown during the war itself. The physical impact of the upheaval - in terms of evacuation, the requisition of buildings and staff shortages - has already been described. Beneath this privation and disruption, however, were pressures which would in 1945 culminate in legislation of far-reaching significance. A spirit of change had been evident even before the war; in fact, the school leaving age for ordinary pupils was to have been raised in September 1939. But although the outbreak of hostilities forced its postponement, in Britain as a whole the war, like World War One before it, appeared to raise the consciousness of those involved in education as to the defects in the system, and demands for action grew.

In Scotland during wartime, 'educational reform was in the air'.[1] As early as 1940, Edinburgh Education Committee found, in the educational world generally, 'a questioning as to whether we are to be content after the war to return to our former aims and methods or whether there are to be revaluations and a new orientation of effort'.[2] A 'groping after a new definition of education and its obligations to humanity'[3] in the early 1940s was also reflected in the Educational Institute of Scotland's journal[4] and in the E.I.S.'s formation of a Reconstruction Committee to consider the shape of post-war education.[5] A substantial contribution to the debate was made by the Association of Directors of Education in Scotland in its 1943 publication,

Education in Scotland: Proposals for Reconstruction, which stressed that children of low intelligence should not leave school with a sense of frustration or inferiority.[6] Official recognition of the need for change also dawned; the Secretary of State's reactivation in 1942 of the previously moribund Advisory Council on Education in Scotland, with an influential membership and a number of important remits, revealed that he too was alive to the necessity for reform.[7] Public opinion was also roused. Whether because of 'the unifying experiences of total warfare',[8] or the influence of the Labour Party, the consensus was moving strongly in favour of equality of educational opportunity, and there was a new determination that education must reflect the ideals and institutions of a more democratic society. Whereas the legislative changes which followed World War One were largely concerned with the administrative reorganisation of education, the 1945 Act attempted to reflect the country's mood of social expectation.

The Education (Scotland) Act 1945 applied Government policy for the development of education in Britain to Scotland, and to a large extent it drew its inspiration, form and expression from the English 'Butler' Education Act of the previous year. The 1945 Act was the most significant educational enactment of the post-war period, and shaped the development of special education for many years to come. Its importance lay not only in its provisions, but in the thinking which lay behind them. The Act recognised that there were inequalities in the abilities and aptitudes of pupils, but stressed the importance of equality of access to educational opportunities and facilities for all those deemed to be capable of benefitting from them.

It placed special education firmly within the main framework of

the education system by making it the education authorities' duty to provide special educational treatment (or 'S.E.T.' as it was generally called) part of their general duty to provide appropriate primary and secondary education for all pupils.[9] The L.E.A.s' functions in respect of mentally handicapped pupils were to be as extensive as in the case of 'normal' pupils; they were required to secure the adequate provision of education for handicapped pupils aged five to sixteen and, in addition, for those aged two to five, and over sixteen, whose parents desired it for them. Further, the Act provided that the provision of S.E.T. did not necessarily involve the provision of separate schools for the handicapped, but could be given either in special schools or by other means approved by the Secretary of State including, by implication, in an ordinary class in an ordinary school.[10] The precise definition of the categories of pupils who required S.E.T., and the arrangements which were appropriate to pupils in each category, however, would be decided by the Secretary of State.[11]

However, although S.E.T. did not necessarily involve the provision of separate schools or classes for the mentally handicapped, it did entail the provision of organised facilities for ensuring that those who required it received it, and from as early an age as possible. To that end, the Act strengthened the ascertainment powers of L.E.A.s. The authorities would continue to be responsible for the ascertainment of school-age children who required S.E.T. but they were also, for the first time, given specific powers to ascertain mentally handicapped children below school age; if the parents of a child who had reached the age of two asked the L.E.A. to examine their child, the authority could not refuse unless it regarded the request as

unreasonable. The contradiction between the 1913 Act's definition of mental deficiency as a condition which existed from birth or from an early age and the lack of ascertainment of pre-school age children thus appeared to be resolved.

The procedures which followed ascertainment were also modified. Where it was decided that S.E.T. was required, the doctor who had undertaken the medical examination was, if required by the education authority, empowered to issue a certificate to that effect detailing the nature and extent of the child's disability. Crucially, however, the certificate was only to be issued if, in the L.E.A.'s view, it was necessary to secure S.E.T.[12] The Act thus abolished the mandatory certification of the mentally handicapped special school entrant.

The Act also significantly extended the definition of 'special schools'. It emphasised the educational orientation of the Scottish child guidance service by including child guidance clinics within the special school category and by specifically empowering L.E.A.s to provide a child guidance service in a child guidance clinic or elsewhere. It also underlined the educational basis of the service in its definition of the functions of the service as the study of handicapped, backward and difficult children, the provision of advice to parents and teachers and, where necessary, the provision of special educational treatment within the clinic.[13] The general impact of this placement of the child guidance service within the educational framework - which did not take place in England[14] - is discussed later in the chapter.

Junior occupation centres were also included within the new definition of special schools. L.E.A.s, therefore, would in future be responsible for providing centres for children who were not educable

but who were capable of deriving benefit from less academic training. Whereas in England the provision of centres for this group was the responsibility of local health authorities, in Scotland some of the children who had previously been the responsibility of the local mental deficiency authority were brought into the education system: again, the special provision which was made for them is described later in this chapter.

In practice, then, the Act created three, rather than two, categories of mentally handicapped children. These were, firstly, the educable who were to receive S.E.T. in 'traditional' special schools (including special classes but excluding junior occupation centres), or by other approved means. There were, secondly, the 'trainable' for whom L.E.A. junior centres were intended. Finally, there were those whose severity of handicap, or behaviour, made them unsuitable even for occupation centres: these 'untrainable' children remained the responsibility of the local health authority. The exclusion of these children from the school system makes it inappropriate to deal with them in this context,[15] and they will be considered here only in so far as they impinged upon the education system. However, the creation, albeit incidentally, of the untrainable category undermines the case for regarding the 1945 Act as 'a proclamation of educational equality'.[16] It did reduce the number of mentally defective children who were excluded from the education system but in doing so it left a residue of profoundly handicapped children who were deemed to be less responsive than circus animals.

The concept of 'untrainability', then, weakened the Act's overall thrust. It also became clear that, whatever the theory of the Act, separate education would continue to be the lot of the mentally

handicapped pupil: the Secretary of State in 1945 stated unequivocally that S.E.T. was to be given in special schools.[17] Nevertheless, the Act in general can be seen as the fruits of one of the rare 'genuine surges of democratic idealism'.[18] Its concern to build a brave new educational world did embrace the majority of the handicapped; by making the education authorities' duties towards the handicapped co-extensive with their duties towards ordinary pupils, by abolishing compulsory certification and by at least acknowledging the possibility of providing special education within the ordinary class, it had narrowed, though not entirely abolished, the gulf between the mentally handicapped and the 'normal' pupil. It was not intended as a self-contained measure, but was drafted with a view to its early consolidation with the Education (Scotland) Acts. The resulting consolidating Education (Scotland) Act 1946 was described by Dr. Jardine of the General Board as virtually 'a charter for the handicapped'.[19] The remainder of this chapter will consider whether subsequent events bore out this optimism.

(ii) Reconnaissance and response

While the 1945 Act had laid the legislative foundation for the post-war development of special education, the Government was conscious of the urgent and still outstanding need to gather together up-to-date information and expert opinion relating to all forms of handicap. In January 1947, the task of providing it was entrusted to the revitalised Advisory Council on Education in Scotland, which was given a remit to review primary and secondary provisions for the education of pupils suffering from disability of mind or body or from maladjustment. Its remit was so vast that it was decided to divide

the findings into self-contained parts and submit each when it was ready. Between 1950 and 1952, the Council produced seven reports, the first six dealing with a major category of handicap and the seventh with the administration of special education generally.[20] Together they formed the first comprehensive study of the educational problems of handicapped children in Scotland.

The Advisory Council's most important report, in this context, was its 1951 report on pupils with mental or educational disabilities. One of its main aims was to provide guidance for the Secretary of State in his categorisation of pupils who required S.E.T., which had been delayed pending the completion of the series of reports. Having decided that 'slow learners' did not fall within its terms of reference, the Advisory Council recommended that mentally or educationally disabled pupils should be divided into five groups. The first two categories - those who required S.E.T. because of absence from, or frequent change of, school, or because of faulty teaching, and pupils with disabilities in particular subjects - related to those with educational difficulties. The mentally disabled were divided into three categories: pupils who were capable of making some progress in scholastic subjects, whom the report termed 'retarded', but who corresponded to the existing 'educable' group; those who were unable to make much or any scholastic progress, but who were trainable; and 'psychotic' children whose personality defects prevented them from benefitting from education, or made them a harmful influence on other children.[21] Untrainable children were not included in this category: the Advisory Council did not propose to make any change in their existing status as 'non-pupils'.[22]

The Special Educational Treatment (Scotland) Regulations 1954,

drawn up in fulfilment of the Secretary of State's duty to define pupils who required S.E.T., however, did not follow this classification. Among the nine categories so defined were 'mentally handicapped pupils';[23] but this group encompassed only two of the Advisory Council's five sub-categories, the 'retarded' and the trainable. Psychotic children were included among those entitled to S.E.T., but as part of another category, the maladjusted. Pupils with educational disabilities were not included among those who required S.E.T. The Regulations thus differentiated between pupils whose problems were the result of disruption to their schooling or of weakness in a particular area of academic attainment, and those whose problems were the result of a general limitation of intellectual capacity. No such distinction had been made in the corresponding English regulations which had been drawn up in the previous year; in England, the mentally handicapped were included in the broader group of 'educationally subnormal pupils' who, for whatever reason, were markedly failing in their school work.[24]

Why, therefore, did the Secretary of State override the Advisory Council's recommendations and diverge from the English regulations by confining S.E.T. to pupils with more purely mental handicap? A different perception of the definition of S.E.T. seems to have been most important. It was defined by the 1945 Act as education by special methods. While 'normal' children who, for various reasons, had fallen behind academically required extra or more intensive tuition, it was doubtful whether they needed to be taught by special methods. As S.E.D. Circular 300, which was issued in 1955 in response to the reports, explained, the Secretary of State did not feel justified in recognising as in need of S.E.T. those whose disability

was caused by external factors;[25] they could, with remedial instruction, catch up with their peers. The provision of S.E.T. was reserved for those whose difficulties were the result of their intrinsic lack of natural ability and who were, by definition, unable to catch up. In its precise definition of who did and who did not require S.E.T. and who should, and who should not, receive it on the grounds of mental disability, the Regulations drew an important distinction between educational underachievement and mental disablement.

The Secretary of State and the S.E.D. also had reservations about some of the Advisory Council's other findings and recommendations. There was a difference of emphasis on the extent to which handicapped children should be integrated into ordinary classes. The Advisory Council's report stressed that while diversity within ordinary schools and classes should be encouraged, the separation of the mentally handicapped in special classes, and preferably in special schools, was necessary both in the interests of handicapped pupils - who could be discouraged by their inability to keep up with other pupils - and in the interests of ordinary pupils, who suffered when mentally handicapped children took up an inordinate amount of the teacher's time.[26] Circular 300, however, though acknowledging that separation was necessary in some cases, felt that, in general, S.E.T. should not be thought of mainly in terms of the large-scale provision of separate schools. The reasons given for this apparent alteration of the views expressed immediately after the 1945 Act were the results of experience, which had 'profoundly modified expert opinion on the question of separation', and the general improvement in the amenities of ordinary schools.[27]

The Secretary of State and the S.E.D. were also reluctant to accept the Advisory Council's estimation of the extent to which existing provisions fell short of requirements. Although it acknowledged that more investigation of the subject was needed, the Advisory Council's report on mental and educational disability estimated that about 40 per cent of educable mentally handicapped pupils were not receiving the S.E.T. to which they were entitled.[28] But although the Secretary of State, in Circular 300, was prepared to admit that provision for this group was inadequate both in quantity and in quality, he was not prepared to accept the Advisory Council's estimate as a satisfactory basis for future planning, since the incidence upon which it had been calculated - that of 1.5 educable mentally handicapped children per hundred pupils - was itself an estimate.[29]

Other factors, however, may also have been involved. Was the Secretary of State's reluctance to accept the Council's estimate prompted by a prudent desire not to proceed on the basis of guesswork or by a desire to minimise expenditure? Was his narrow definition of those entitled to S.E.T., and Circular 300's stress on integrating the handicapped into ordinary schools, spurred by similar considerations? Direct evidence of this is lacking but the Government's general anxiety to minimise public expenditure was shown in the reception given to the report on the welfare needs of the mentally handicapped which was completed at about the same time. This report, by the Scottish Advisory Council on the Welfare of Handicapped Persons, found that there was a pressing need for more day and residential special schools, and for more occupation centres.[30] Publication of the report was held up because of financial reasons and it was eventually issued

with a circular stressing the impracticality of implementing it.[31] It therefore seems likely that the official reaction to the A.C.E.S. report's major recommendations on mentally handicapped pupils was at least partly inspired by the demands of economic stringency: indeed the length of time the response took to come may itself have been significant. The same motive may also have contributed to Circular 300's reaction to some other proposals of the A.C.E.S.

For while the Secretary of State had doubts about the Advisory Council's view of the general shape and size of the provision which was needed for the mentally handicapped, he also had reservations about some of the report's more specific recommendations. While the Advisory Council felt that day special schools were generally preferable, it was convinced that the difficulties of providing special education in rural areas could only be overcome by the provision of residential schools and hostels for mentally handicapped pupils.[32] Circular 300, however, expressed the Secretary of State's grave doubts about the practicality of providing hostels, and emphasised the importance of educating pupils in the environment in which they belonged.[33] There were also differences of opinion about teaching methods and the content of the curriculum. The Advisory Council, in all its reports, laid emphasis upon the need for individual teaching methods and personal experience and activity, but Circular 300 stressed that group and class activities, and more 'formal and old-fashioned' methods still had an important role in special education.[34] Nor did the Secretary of State share the Advisory Council's views on vocational training for older handicapped pupils; while the Advisory Council stressed the importance of vocational training to avoid the handicapped becoming 'misfits' in the

community,[35] the Secretary of State felt that the proper place for it was in a course of further education rather than in the special school.[36]

There was also disagreement about the future administration of special education generally, which was the subject of a 1952 Advisory Council report. The Council was convinced that the particular needs of special education required the creation of a central body which would plan a comprehensive service, draw the Secretary of State's attention to inadequacies in the service and co-operate with the central and local authorities, especially in the area of ascertainment; it should be a special committee of the Advisory Council.[37] Circular 300, however, reflected the Secretary of State's opinion that the recent establishment of a Working Party on Handicapped Children made the creation of another body superfluous. The Working Party, set up following a conference on 'The Needs of Handicapped Children' which was held in 1950 under the auspices of the Association of Directors of Education in Scotland and the Scottish Council for Health Education, comprised a wide variety of voluntary and statutory organisations and the Secretary of State felt it could, in an unofficial capacity, fulfil the functions of the proposed official body.[38]

However, the areas in which the official response to the Advisory Council's recommendations was less than enthusiastic should not obscure the fact that there were many matters upon which the Advisory Council and the Department were in more or less complete agreement. At the most basic level, there was unanimity on the need for a general expansion of special education for mentally handicapped pupils. There was also a consensus that it should be based upon ascertainment which was thoroughly and carefully undertaken, and that

mental tests should form part of the assessment process: Circular 300 accepted the Advisory Council's recommendations that those with I.Q. levels of circa 55-70 fell into the educable category, while those with I.Q.s of 40-55 should be considered ineducable but trainable. Both, however, shared the conviction that the I.Q. must not be used as the sole means of categorisation, but should be supplemented by other methods such as teachers' estimates and, in doubtful or borderline cases, the results of a probationary period in an ordinary or special school, or in an occupation centre.[39] There was also agreement on the need to develop the secondary component of secondary education, on the desirability of avoiding stigmatising terminology[40] and on the unacceptability of admitting mentally handicapped pupils who required S.E.T. to institutions for certified mental defectives.

Nevertheless, it was the areas of disagreement which were most striking. The Advisory Council did valuable work in highlighting the general deficiencies of special education and in drawing attention to some of the problems which needed to be tackled, but the general feeling appeared to be that its reports on handicapped pupils were, as a whole, less impressive than its work on ordinary education.[41] The official response to its recommendations on mentally handicapped pupils did not suggest that many of them would be implemented in the near future. The legislation of the mid-1940s and the reports of the early 1950s had not solved the grassroots difficulties of the service; in fact, the hiatus between the start of the Council's work in 1947 and Circular 300 in 1955 had, by encouraging a 'wait and see' attitude among the central and local education authorities, if anything exacerbated them.

(iii) Implementation and further investigation

The development of special education during the post-war period was hampered by an inadequate infrastructure. In the years after the war, the general climate of economic retrenchment meant that little progress was made in the provision of new accommodation, or in the improvement of existing schools. The situation eased somewhat in the mid-1950s and in the latter years of the decade new schools for the mentally handicapped were planned - and in some cases opened - in a number of areas, including Aberdeenshire, Invernesshire, Perthshire and Glasgow.[42] However, the limited scale of the new provisions not only resulted in the widely acknowledged, if imprecisely calculated, shortage of special school places but also meant that some mentally handicapped pupils continued to receive their education in unappealing, even Dickensian, surroundings. The 'obsolete [and] deplorable' condition of some special schools[43] - which was partly, perhaps, due to the persistence of the attitude that the handicapped should be grateful for anything[44] - was, in turn, hardly likely to increase the standing of special education in the eyes of the parents of handicapped children, the teaching profession or the public at large.

In rural areas, the position was especially difficult, since the scattered population made it difficult to gather together in one centre a sufficient number of mentally handicapped pupils to open a special school. One answer was multi-handicap schools; that is, schools which contained both mentally handicapped and physically handicapped pupils. Despite the considerable body of educational opinion which held that the mentally handicapped should not share schools with the physically handicapped,[45] there were a number of these schools in the post-war period and not all of them were in rural

areas; Hamilton, Coatbridge and Motherwell were among the towns which had special schools containing classes for the mentally handicapped and for the physically handicapped under one roof, and in Motherwell pupils with 'double defects' attended the same class.[46] The alternative of special classes for the mentally handicapped in ordinary schools was also widely utilised in the post-war years, but even this was impracticable in very thinly populated areas.

Education in a mental deficiency institution was another option. In some cases children were transported daily to classes held in institutions, but this was only practicable where the institution was within reasonable commuting distance. Institutions were, in any case, generally ill-equipped to deal with educable children, not least because they did not normally have certificated teachers on their staff.[47] But day attendance at an institution was at least preferable to the admission of high-grade handicapped children to institutions. While a period of residential care might be necessary for maladjusted or unstable educable children, the admission of others to institutions because there was no alternative educational provision was objectionable; not only were the facilities available there for their education generally inadequate, but certification, though no longer necessary for entry to a special school, was still a pre-requisite for admission into an institution. It is not clear how many children were institutionalised because of the dearth of facilities for S.E.T. in their area: the acute shortage of mental deficiency beds must certainly have limited their numbers.[48] Nevertheless, the fact that it did happen in the years after 1945 was one of the most unfortunate aspects of special education in the post-war period.

It therefore seemed that some special means would have to be

found to enable children outside cities and towns to receive the education to which they were entitled. The provision of more residential places seemed to many to be the ideal solution, since boarding schools for mentally handicapped pupils would ameliorate the difficulties caused by geography and demography. Moves were made in the late 1940s and early 1950s to establish such a school in the Highlands, but progress, here as elsewhere, was hampered by restrictions on new building and the difficulty of finding existing premises which could be used without extensive and expensive alteration. The project was also dampened by the S.E.D.'s belief that action should be deferred pending consideration of the Advisory Council's recommendations;[49] and Circular 300, with its emphasis on retaining handicapped children in their home surroundings, was also not encouraging. Some progress was made during the second half of the 1950s: the opening of Raddery House boarding school for mentally handicapped pupils was particularly welcome in a rural area like Ross and Cromarty.[50] Even by 1960, however, residential places formed only a tiny fraction of total special provision.[51]

Provision for the post-primary education of mentally handicapped pupils, despite the 1945 Act's recognition that S.E.T. had a secondary stage, and its reinforcement by the Advisory Council, remained especially limited. Tentative steps were taken in the 1950s to expand the secondary sector,[52] but many L.E.A.s found it difficult enough to provide S.E.T. for younger pupils and it was not possible, in most areas, to provide secondary schools for the mentally handicapped. All-age special schools therefore were the norm and, largely because the staff were not equipped to teach a secondary-type curriculum, they generally retained a primary school orientation and

were slow to develop curricula and methods which were adapted to the changing needs of adolescent pupils. Older pupils, however, were, despite Circular 300's attitude, often provided with vocational training in practical subjects;[53] but a shortage of adequate facilities and appropriately trained staff hampered vocational work in some cases.[54]

Special education also suffered staffing problems. An improvement in the training of teachers was made in 1951 when the course for teachers of the mentally handicapped at Jordanhill College was extended from fourteen weeks to four months; it was rún - so long as they dealt with common problems - conjointly with a new course for teachers of the physically handicapped (after which point separation took place to allow appropriate specialisation).[55] More opportunities for training were also provided in 1956 when a new course at Moray House College joined the existing courses at Jordanhill and Aberdeen.[56] But while these courses provided some point of contact between the different types of special school teachers during training, teachers of the mentally handicapped remained largely isolated from the rest of the teaching profession. There was little interchange and the wider profession was, in many cases, largely ignorant about special education. What was still widely regarded as something of an educational backwater was unlikely to enjoy high esteem, or to appeal to the highest calibre candidates, and special education's unattractiveness meant that trained teachers remained in short supply.[57]

Progress was made despite these problems, but although the number of mentally handicapped pupils in special schools increased by more than one thousand in the decade following the legislation of the 1940s,[58] there was a general conviction that this was not enough.

Accurate information, however, was lacking; the Advisory Council had only estimated the extent of the overall shortfall, and even that had not been accepted. The Working Party on Handicapped Children, whose existence, as has already been described, was used by the Secretary of State to reject the need for a permanent and official central planning and advisory body to mcnitor the development of special education, set about providing precise data. Its report was originally submitted to the Secretary of State in August 1954, but it was subsequently agreed that publication should be deferred until Circular 300 had been issued. In September 1955 it was further agreed that the report should be revised, and it was only after a long delay that the Working Party's report was finally issued in 1958.[59]

The most important part of the report was its analysis of the scale of the provisions which were needed to ensure that mentally handicapped pupils received the special education to which they were entitled. It therefore went beyond the Advisory Council by providing estimates of the numbers of handicapped children who were likely to be found in each L.E.A.'s area.[60] The report was enclosed in a circular sent to education and health authorities in September 1958. In it, the Secretary of State welccmed the report, but he did not commit himself to accepting or implementing its recommendations. Nevertheless, he did admit that in many cases the report's estimates differed considerably from the number of children known to be receiving S.E.T. Education authorities were accordingly asked to examine ascertainment in their area, and to inform the S.E.D. of their findings.[61] Their reactions confirmed that in many areas the numbers ascertained fell far below the Working Party's estimates, and the shortfall was particularly pronounced in the case of the mentally handicapped.[62]

This highlighted the disturbing fact that almost half a century after education authorities had been given a statutory responsibility to ascertain mentally handicapped children there was still confusion about the number of the mentally handicapped who required to be dealt with, and consequently about the amount of provision which was needed. Some authorities, particularly those in areas where few special school places were available, were perhaps not particularly interested in disovering the extent of the needs which had to be met. However, the lack of any generally accepted standards for ascertainment provided them with a justification for inaction, and hampered those L.E.A.s which were concerned to conscientiously discharge their duties. Of the three main methods of ascertainment, mental testing had claims to objectivity and in the case of the I.Q., the Advisory Council's report on the mentally handicapped had provided criteria for the placement decision. The evidence of physical signs, however, and the child's rate of developmental progress were subjective and unstandardised: at what point did a delay in walking, talking, reading or writing indicate handicap, educability, trainability or untrainability? The results of a probationary period of education were useful and many borderline cases were given the opportunity to prove their suitability or otherwise for an ordinary or special school.[63] In assessing the results, however, L.E.A.s faced the problem that the point at which the child could be deemed to have passed or failed the test was nowhere defined. It was unrealistic to expect rigid uniformity in classification, but if categorisation was to be based on a solid foundation of accurate ascertainment and if it was to be as objective as possible, however, some more standardised criteria for the placement decision would have to be found.

The task of providing them was in 1960 entrusted to the Working Party on Standards of Ascertainment for Scottish Schoolchildren, which issued its report on the mentally handicapped in the following year.[64] The report's tone was 'eminently cautious',[65] and emphasised the complexity of the categorisation decision and the lack of sure and simple criteria for it. It was at pains to stress that the classification of the mentally handicapped was, in borderline cases, always to some extent arbitrary and subjective.[66] In a prudent, even gingerly way, however, it did provide L.E.A.s with guidelines.

The most important part of the Working Party's remit was the determination of the borderline between those who required ordinary education and those who needed S.E.T. The report felt that mental tests were valuable predictors of performance, and that, in the cases of children who were near the upper end of the handicapped range, a good deal of weight should be attached to the results. But although it, like the Advisory Council a decade earlier, accepted I.Q. 70 as the rough line of demarcation between normal intelligence and handicap, the Working Party laid even more emphasis than the Advisory Council had done on the importance of practical experience. The child's ability or inability to profit from ordinary education, and not his or her theoretical store of native intelligence, must form the basis of the placement decision, and a child near the upper limits of the handicapped group must not be denied normal schooling until he or she had tried it and failed. Crucially, the Working Party also provided a yardstick by which success or failure should be judged, recommending that if a child could not learn at such a rate as to match the attainments of children of average ability who were 30 per cent younger, then he or she was not suitable for an ordinary school.[67]

The Working Party's terms of reference also required it to provide guidelines for the categorisation of those within the broad group of the mentally handicapped as either educable, trainable or untrainable. In the case of the first category, the report, though agreeing with the Advisory Council that I.Q. 70 was the approximate upper limit of the category, recommended that I.Q. 50, rather than I.Q. 55, should be regarded as the lower limit. But it stressed that suitability for special schooling should also be based on an assessment of the child's abilities in such areas as vocabulary and communication, attitudes to other people and degree of independence - for which it provided guidelines - and, in borderline cases, on the results of a probationary period.[68]

The Working Party made similar recommendations regarding a trial period and developmental assessment in the case of children suspected of being in the second category of trainable, although in their case a lower level of personal and social attainment would be expected.[69] But while it recommended I.Q. 50 as the upper limit for this category, the Working Party did not accept the Advisory Council's figure of I.Q. 40, or any other figure, as the lower limit. This in part reflected the Working Party's view that the I.Q. was not such a useful tool for the categorisation of lower-grade children as it was for higher-grade children.[70] It also, however, reflected its questioning of the concept of untrainability. A breach in the wall of pessimism that surrounded the profoundly handicapped had already been made by the Mental Health (Scotland) Act 1960 which, in a minor but nonetheless significant terminological modification, had replaced the definition of untrainable as being those 'incapable' of benefitting from training by the new term (section 11 and the First Schedule)

'unsuitable' for training. The Working Party underlined the change both in its refusal to recognise any lower limit on trainability and by its assertion that with few exceptions it was a mistake to assume that any child was unable to respond to training.[71] It did, as its terms of reference required, provide developmental guidelines for classification as untrainable,[72] but its attitude reflected the growth of a perception which would lead to the category's abolition in 1974.[73]

It was, as the Working Party itself recognised, impossible to eliminate the large element of subjectivity inherent in the categorisation of the mentally handicapped. It was also certain that ascertainment would continue to be dependent upon factors such as the amount of provision which was available and the assiduity of the ascertainers. But the Working Party, particularly in its provision of detailed guidelines as to the developmental standards which should be used in assessment, had at least provided the criteria and strategy by which more thorough, uniform and accurate assessment could at last be achieved.

Its impact, however, would be felt in the years after 1960. It was, in the context of this chapter, the end rather than the beginning of a process, the last part of a chain reaction which had been sparked off by the legislation of the 1940s and which had, via the reports of the Advisory Council, the Working Party on Handicapped Children and the Working Party on Ascertainment itself, highlighted the deficiencies in special education: 'expectations had been raised [and] areas of uncertainty, ignorance or failure exposed'.[74]

The identification of problems, however, did not automatically lead to their solution. The answer to some of the difficulties of

special education - including the shortfall in special school places, the lack of residential provision, the under-developed secondary sector and the low esteem in which the service was generally held - seemed almost as far away in 1960 as it had in 1945. There was no single or simple explanation for this. Financial, demographic and geographic factors all played a part. So, too, did a lack of central direction from an S.E.D. which, in its attitude to ascertainment, vocational training and residential schools, did sometimes appear 'an unduly cautious [and] unimaginative ... institution'[75] which did not give a strong enough lead to L.E.A.s which were not prepared to give a high priority to special education for the mentally handicapped. Traditional special schools, however, were only one facet of Scottish S.E.T. The remainder of this chapter discusses the post-war development of the junior occupation centres and child guidance clinics which were also part of the education system.

(iv) Junioroccupation centres

It is difficult to precisely define children who attended L.E.A. junior occupation centres, since in the late 1940s and the 1950s there were no universally accepted criteria for the decision to categorise a child as ineducable but trainable. Mental tests played a part, but other factors were also taken into account: the centres were, for example, unlikely to accept children who were likely to prove a disruptive influence. The results of practical experience were also used in some cases; while some children were admitted to J.O.C.s directly - that is, without having received education elsewhere - others were admitted following a trial period in a traditional special school.[76] It also seems likely that, after a period in an L.E.A.

centre, others were 'weeded out' as more suitable for L.H.A. care. But the point at which the lines of demarcation between educability, trainability and untrainability were drawn could also depend on the amount of provision available locally in traditional special schools, mental deficiency institutions and J.O.C.s themselves; and the only generalisation that can be made about J.O.C. pupils is that, in terms of their intellectual and other attainments, they formed an intermediate group between traditional special school pupils and the 'untrainables' in L.H.A. care.

In keeping with the intellectual level of their pupils, the work done in junior centres was much less academic, and less structured, than that of traditional special schools. Broadly, J.O.C.s tried to inculcate in pupils habits of personal hygiene, socially acceptable behaviour and useful social skills. There was, in most cases, no rigid timetable and informal instruction was given in such areas as colour, shape and size discrimination and everyday counting. There was also an emphasis on exercises designed to improve speech, balance and co-ordination, and on dancing, music and physical education.[77] Many occupation centre pupils were unlikely ever to be able to take up normal employment, but the centres aimed to render the pupils as self-reliant and adjusted to 'normal' society as possible.

The difference between junior centres and traditional special schools was also reflected in the fact that J.O.C.s were generally staffed not by qualified teachers but by instructors or, more commonly, instructresses. Some training for instructors was provided in the late 1940s by the Scottish Association for Mental Health[78] and in 1950 the National Committee for the Training of Teachers, at the instigation of the S.E.D., started a sandwich course,for experienced

instructors,at Jordanhill Training College.[79] The number of instructors gaining this qualification increased the number of trained staff in J.O.C.s, and there did not appear to be any shortage of those willing to undertake the work.[80] Nevertheless, for much of the period junior centres were staffed by those who, though they often had a background in 'social welfare work', had no formal training in either teaching or mental deficiency.[81]

It was perhaps because of the differences between J.O.C.s and 'traditional' special schools that the position of junior centres came under scrutiny in the late 1950s. The Scottish Health Services Council's 1959 report on community services for the mentally disordered felt that the division of responsibility for occupation and training between L.E.A.s which ran centres for trainable children and L.H.A.s charged with 'untrainables' and defectives over sixteen made the provision of an integrated community service unnecessarily difficult. It also believed that the social and medical elements involved in the training of handicapped children made the work more appropriate to L.H.A.s, which were better equipped to deal with multi-handicap cases, and which could keep the centres open during the holidays. For these reasons, therefore, the Committee recommended that the duty of providing J.O.C.s for trainable children should be transferred to L.H.A.s.[82]

This proposed removal of ineducable but trainable children from the education system, however, was not popular. The Committee had itself acknowledged one of the major stumbling-blocks to transfer; the consensus among those in the educational field that the parents of handicapped pupils preferred the existing system.[83] But there was also a conviction, articulated by the Scottish Association for Mental

Health, that the 'learning' element in the training of juvenile defectives was at least as important as the medical component, and justified the retention of the status quo.[84] In the face of this opposition, the recommendation was not implemented, and Scottish junior centres remained part of the school system.

This decision did seem to be justified. While L.H.A.s did little to provide centres for the untrainable defectives for whom they were responsible,[85] L.E.A.s seemed, as the S.E.D. asserted in 1957, to be paying increased attention to the needs of trainable juveniles.[86] There were, by 1957, thirty-two occupation centres with 1,033 pupils: by 1960, there were 1,325 pupils in forty-three centres.[87] This was still below the 1,609 places which the Working Party on Handicapped Children had in 1954 estimated were necessary,[88] but, compared to the provision made by L.H.A.s and given the problems, already described, which faced special education generally, the progress which had been made was encouraging.

In general, however, the Scottish policy of placing and retaining J.O.C.s under the educational rather than the medical umbrella did have some drawbacks. The problem of co-ordination had been identified by the S.H.S.C. Committee; the Scottish system may also, incidentally, have put those untrainable children who remained an L.H.A. responsibility in a particularly stigmatising position. Nor should the degree of integration between J.O.C.s and the wider system be overstated. Administrative arrangements could not eradicate the differences between the centres and traditional special schools; indeed, the very term 'occupation centre' connoted 'limited expectations of potential and achievement'.[89]

Nevertheless, there were strong arguments in favour of the

Scottish policy. Although differentiated by their curricula and staffing, Scottish J.O.C.s were still 'special schools', and, despite their lower levels of intelligence, those who attended them were still 'pupils'; in an area where language had such potentiality for the encouragement of positive or negative attitudes, terminology was significant. J.O.C. pupils were marked out by many factors, but they were at least the responsibility of the same local authority as 'normal' children of school age. This administrative arrangement may have helped to ameliorate some of the shame which attached to mental handicap and for this reason alone was surely, on balance, to be welcomed.

(v) The child guidance service

The placement of Scottish child guidance clinics within the education system also seemed vindicated by the progress which was made in the post-war years. While there had been about a dozen clinics on the outbreak of the Second World War, there were twenty-seven L.E.A. clinics by 1952.[90] The most advanced service in the country was, not surprisingly, to be found in the largest city. The service in Glasgow in the post-war years offered a range of facilities which included psychological, educational and psychiatric investigation, relaxation and remedial exercises, play and speech therapy, to clients ranging from pre-school-age children to young adults. It also undertook special surveys of the intelligence of various categories of pupils in order to assist the development of educational policy in the city, provided case reports for social workers and probation officers, gave talks and lectures on its work, and assisted neighbouring authorities with particularly difficult cases.[91] It appeared that the

service could offer 'any possible treatment required for the welfare of children',[92] and increasing use was made of it.[93]

Glasgow, however, was far from typical of the Scottish service as a whole. Its resources, and those of other urban areas, enabled them to provide a service which most education authorities could not emulate. There were still wide variations in the provisions available in different parts of the country. Twenty-three of the twenty-seven L.E.A. clinics in existence in the early 1950s were in Glasgow, Edinburgh, Dundee, Ayrshire and Fife; and Glasgow and Ayr alone, with twelve and six clinics respectively, contained two-thirds of the total number of clinics in Scotland.[94] This disparity in facilities was also reflected in the service which was provided. The confirmation of the presence of suspected mental defect was an important part of child guidance work in every area, but many counties were forced to confine their work to assessment and categorisation, and could not provide a clinical service. In some rural areas the child guidance service was still non-existent in the early 1950s.[95]

This imbalance in provision was one of the major concerns of the Advisory Council on Education's 1952 report on maladjusted pupils. It emphasised that the first priority must be the general expansion of the service, and it felt that the major obstacle to this was the permissive nature of the L.E.A.s' power to provide a child guidance service, which some had used to avoid making the necessary provision. As a prerequisite for the proper development of the service, therefore, the Council recommended that the establishment of a child guidance service by L.E.A.s be made mandatory. Many of the problems of sparsely populated areas, it felt, could be overcome by the combination of authorities for child guidance purposes.[96]

The Council's report recognised, however, that, whether mandatory or not, an efficient child guidance service depended to a large extent on the quality of staff. It stressed that child guidance psychologists must be both qualified and experienced, and recommended that clinics should have a social worker - and preferably one with psychiatric experience - on their staff. A clinical psychiatric service must, even in educationally biased clinics, be available to those who needed it: Regional Hospital Boards, it felt, could play an important role in the provision of psychiatric services. Indeed, the Council emphasised the need for co-operation at every level between all the statutory and voluntary agencies concerned with child guidance.[97]

The Advisory Council's report, then, highlighted some of the inadequacies of the Scottish service and provided a blueprint for its future development. The official response to it, however, was disappointing. The Secretary of State approved all its recommendations but one; unfortunately, however, it was the one upon which many of the other proposals depended. He was not prepared to make the establishment of a child service mandatory, on the grounds that the shortage of child psychiatrists made it undesirable to make further demands upon the limited number who were available.[98] The subsequent development of the service during the 1950s thus had to take place without the spur of compulsion.

However, it was doubtful whether making the provision of a child guidance service obligatory would have solved many of the problems which dogged the service in the post-war years. One of these problems was the on-going struggle for the heart, or soul, of the service. The pre-war tension between psychologists and educationalists

on the one hand, and psychiatrists on the other, has been described in chapter 4. But the legislation which had placed the child guidance service within the education system, far from resolving the dissension, appeared to exacerbate it.

Some of this friction may have arisen from the professions' insufficient appreciation of each other's worth. Psychiatrists did not, perhaps, realise that psychologists in the child guidance service underwent a long and exacting training before qualifying,[99] while some educationalists, like D.S. Petrie, an Inspector of Schools during the 1950s, thought that the training of child psychiatrists left a lot to be desired, and perceived psychiatry as riven by doctrinal disputes.[100] But this lack of confidence and misunderstanding seems to have sprung from a deeper-seated cause; from, in fact, the professions' very different approaches to the problems of human behaviour. Put simply, psychiatrists regarded deviation as the result of illness which must be treated, while psychologists and educationalists believed that it was the result of learning wrong habits, and that re-education was the answer. As a result, some psychiatrists felt that psychologists and educationalists were exceeding their proper role, and intruding into the psychiatrists' domain, by dealing with problems which were essentially medical,[101] while psychologists and educationalists resented what they saw as the unnecessary 'medicalisation' of learning, personality and behaviour problems.

The struggle reached a peak in the 1950s, and was mirrored in the professional jealousies and rivalries that the service was fraught with. The dominance of the psychiatrically controlled clinic in England created pressures for the psychologically and educationally based Scottish service, and it sometimes appeared that psychologists

and educationalists were under siege from those who wished to import the alien model of the medic king and his psychologist courtiers. Dr. McCallum, head of the Glasgow Corporation child guidance service in the early 1950s, felt that there had been an increase in the propaganda from the psychiatric lobby who were interested in trying to limit the role of psychologists.[102] The Association of Directors of Education in Scotland was also disconcerted by what it saw as an attempt to bring the medical side of child guidance into undue prominence,[103] while the S.E.D., too, was conscious of efforts to prove that child guidance work was essentially psychiatric.[104] The strains within the service even percolated through to the clients, and it was alleged that in some instances the treatment of a case had been adversely affected by one profession's failure to make prompt use of the services of another.[105]

It would be inaccurate, however, to characterise the post-war period as one of unrelenting strife among diametrically opposed professional groups. On an individual level, many psychologists, educationalists and psychiatrists continued to work, as they had always done, as a team and with every appearance of harmony - the service in Glasgow, despite Dr. McCallum's comments, appears to have largely avoided the internal conflict that affected other areas.[106] In the end, a compromise, or at least a ceasefire, was reached. Psychologists and educationalists, though still unwilling to accept what they saw as a 'second fiddle' position, at least conceded that pscyhiatrists had an essential part to play in the service. Psychiatrists, on the other hand, recognised that the Scottish service could not easily be made to fit the English medical model. It would, as Petrie commented, be idle to ignore the disagreements concerning

the identity of the child guidance service which took place in the post-war period. Many professionals, however, came to agree with him that it would be folly to perpetuate them.[107]

However, the reluctance with which some psychologists and educationalists acknowledged that psychiatric services were a vital part of child guidance was a contributory cause of the general inadequacy of those services. The shortage of psychiatrists with knowledge and experience of treating children, however, was equally important: since child psychiatry was a much later development than child psychology, there were, throughout the period, a mere handful of child psychiatrists in Scotland.[108] As a result, psychiatric services were rarely provided as an integral part of the child guidance service.

There were exceptions: in some cases, as at Notre Dame Voluntary Clinic, psychiatric treatment was available within the clinic. In many instances, however, children who required psychiatric services had to be referred elsewhere. Referral might be to one of the specialist child psychiatric clinics - like that at Edinburgh's Royal Hospital for Sick Children - that had been established in the hospital service. But there were only a few of these clinics,[109] and in most cases children were referred to one of the out-patient clinics - at general or mental hospitals - which primarily catered for adults. Psychiatric in-patient facilities for children with serious behavioural disorders, too, were - despite the opening of a number of residential units in hospitals during the 1950s[110] - similarly limited.

As a consequence of this shortfall in provision, and also, perhaps, because of poor inter-professional relationships, it seemed

that some psychologists did treat children with severe psychiatric disorders without reference to a psychiatrist.[111] Psychiatrists' fears that some psychologists dealt with cases which were outside their proper sphere thus appeared to be at least partly justified. It is difficult to assess the prevalence of this problem, but in a more general sense, the inadequacy of psychiatric services was undoubtedly the major disadvantage of the educational and psychological basis of the Scottish child guidance service and of the 1945 Act which had enshrined it.

Surprisingly, perhaps, the psychological service in Scottish clinics, despite the primarily psychological orientation of the service, continued to fall short of requirements. The shortage of educational psychologists was one limiting factor,[112] but psychological treatment was also restricted as a matter of policy. The pre-war policy of excluding mentally handicapped children, or even those of low intelligence who were not actually handicapped, was continued. The Advisory Council's report on the service found that many clinics refused to treat children whose I.Q. was below 85,[113] and there was a lower limit of I.Q. 90 on admissions to Nerston residential clinic.[114] The policy was based partly on an assumption that handicapped or 'dull' children could not derive much profit from psychological treatment,[115] but it was also a consequence of the service's limited resources. The Advisory Council was convinced that children of lower intelligence should not be barred,[116] but many clinics continued to confine their work with this group to investigation, diagnosis and advice-giving. Few were prepared to provide clinical treatment once handicap had been confirmed.

The educational and psychological basis of the service was also

one of the reasons why few psychiatric social workers were employed in Scottish child guidance clinics in the immediate post-war years, when it was widely held that the teacher psychologist who treated cases in the clinic should also undertake domiciliary visitation. There was also, however, an acute shortage of P.S.W.s. There were more opportunities for training; a course for P.S.W.s - only the second in Britain - had begun at Edinburgh University in 1944 and other courses were subsequently established at a number of English universities.[117] The outlets for their services, however, increased at a faster pace as more Scottish clinics, with their expanding case-loads, gradually started to realise that P.S.W.s could play a vital part in the work.

As a result, many clinics found it almost impossible to recruit P.S.W.s. Glasgow Education Department, for example, eventually decided in 1952 that the services of P.S.W.s were required, but the vacancies remained unfilled two years later.[118] Psychiatrically biased clinics, with their different orientation and multidisciplinary tradition, appeared to find the recruitment of social workers easier than did L.E.A. Clinics: Notre Dame Clinic, for example, had several P.S.W.s and a family caseworker on its staff by the late 1950s.[119] But Glasgow's experience was far from unique and so long as demand continued to outstrip supply there seemed little likelihood of P.S.W.s making a larger contribution to the work of the L.E.A. child guidance service.

Despite these difficulties, however, both the quality and coverage of the service generally continued to improve. By 1957, fifteen L.E.A.s, containing 80 per cent of the children in the country, had child guidance services of their own,[120] and in that year, too, Scotland's second residential child guidance clinic was opened, in

Maybole,by Ayrshire Education Authority.[121] Voluntary clinics like Notre Dame, though they played a proportionately smaller role in the post-1945 service, continued to provide a generally high standard of service, and the mutual benefits of close co-operation between the voluntary and statutory sectors were generally recognised. There was also evidence of closer co-operation among the various statutory agencies concerned with children's development. One of the most innovative moves in this direction came with the establishment of a child guidance clinic at Stranraer Health Centre in 1961; the administration of the clinic was, uniquely at that time, shared by the Hospital Board, the L.H.A. and the L.E.A.[122]

By the end of the period, however, there were still some unresolved difficulties. Some L.E.A.s still did not have a child guidance clinic of their own. The problem of the shortage of P.S.W.s seemed intractable. Above all, there was an outstanding need for more adequate psychiatric services. Nevertheless, the improvements which had been made in the infrastructure and staffing of the service since 1945 enabled it to provide a more comprehensive service for a much larger number of clients.

This mixture of substantial even impressive progress and considerable underachievement was, to a large extent, the post-war story of S.E.T. in general. As the war-time sense of urgency faded so, too, did the impetus that it engendered. Perhaps disappointment was inevitable. It may be that in the euphoria of victory, unrealistic expectations had been held out for special education, expectations which were destined to be dampened, if not dashed, by the cold water of experience and expedience. A report card on S.E.T. in the post-war period, therefore, might read 'must do better'.

Chapter 9 A New Hospital Regime?

(i) Post-war problems

(ii) New methods and therapies

(iii) The new dynamism

(i) Post-war problems

The introduction of the N.H.S. created an atmosphere of expectation. The public had a new sense of proprietory interest in the service, and there were insistent demands for improvements. But in the years after 1948, the society which had created a comprehensive health and welfare system was faced by the need for financial stringency, and both the Labour Government which introduced the N.H.S. and the Tory administration which succeeded it found that their capacity to develop the new service was hampered by economic circumstances. The opening section to the chapter describes the effect of this on the institutional service for the mentally disordered. Later sections discuss the therapeutic innovations and organisational experiments which took place despite financial austerity, and consider their impact upon the mental hospital population.

Any expectation that the introduction of the N.H.S. would in the short-term lead to a radical improvement in institutional provision was soon shattered; major building projects were not possible. The mental health service was particularly affected by the situation. Whereas new general hospitals - notably the seven Departmental hospitals built during the war - had been recently erected, the fabric of the mental health service was old. The seven Royal hospitals all pre-dated the beginning of general statutory provision for the insane in 1857, and many other mental hospitals had been built as parochial asylums; the last mental hospital to be built was still Renfrew District Asylum in 1909. Moreover, the mental hospital service was also disadvantaged by the low priority afforded to it. Its position in the backseat was underlined in 1953 by the Department of Health for Scotland, which asserted that other types of hospital,

'by their nature', required more 'elaborate' provision for diagnosis and treatment than did mental hospitals.[1]

Regional Hospital Boards and Boards of Management which were in some cases still struggling to establish a good working relationship therefore had to make the best use of their limited resources. Building work was in most cases confined to essential maintenance and the adaptation of existing buildings; in 1950, for example, only 0.6 per cent of the estimated total expenditure of Regional Hospital Boards was spent on capital buildings and equipment.[2] Rationalisation was the watchword and mental hospitals were forced to improvise in order to provide 'new' accommodation; at Bellsdyke Hospital, Stirlingshire, for example, the nurses' home was converted for patients' use.[3]

The situation in the mental deficiency service, however, was much worse. It was similarly affected by the constraints on capital expenditure, but the impact of economic stringency was, for two main reasons, even more marked. The post-N.H.S. mental deficiency service was, firstly, beginning from a much lower base; there were, in 1948, far fewer mental deficiency beds, and there were no N.H.S. beds at all in the Northern Hospital Region. The mental deficiency service was, secondly, much less dynamic than the mental hospital service. The institutional population was essentially static, with only a tiny percentage of patients being discharged annually.[4]

Some mental deficiency accommodation was provided by a re-distribution of beds - the success of the fight against tuberculosis released some former TB wards for mental deficiency purposes, and some mental hospital accommodation was converted for the use of defectives.[5] There was also some extension of existing accommodation,[6] although in

some cases the new beds provided merely replaced unfit accommodation and did not increase the total number of beds.[7] All these measures in fact did little more than scratch at the surface of the problem.

The effect of the lack of new accommodation, coupled with the slow turnover of patients, was little short of disastrous. There was an acute shortage of mental deficiency accommodation. Huge waiting lists built up; at one mental deficiency institution alone, over four hundred patients were on the waiting list by the mid-1950s.[8] But even this was not an accurate reflection of the seriousness of the situation. Some institutions simply closed their waiting lists. In other instances, Duly Authorised Officers and others, recognising the futility of doing so, did not submit the names of those who required beds.[9] The scarcity even extended to the State Institution for defectives of dangerous or violent propensities, which was forced to refuse requests made by the Courts to admit patients.[10] By the mid-1950s there was, in effect, only half the number of mental deficiency beds required, and at least five thousand more were urgently needed.[11] The situation was one of emergency which was steadily becoming more serious.

Indeed, the situation would have been even worse if it had not been for voluntary religious effort, which played a significant role in the provision of accommodation. In the 1950s, the five Roman Catholic Certified Institutions provided almost one-ninth of the total institution accommodation for mental defectives. Almost all their beds were used for N.H.S. patients - not all of them Catholics - received under contract. Two of them - St Mary's, Barrhead and St Mary's, Galashiels - accommodated adolescent and adult females. Two - St Charles', Carstairs, and St Joseph's, Rosewell - were primarily for

children, while St Aidan's, Melrose, accommodated adolescent and adult males. Together, they provided, by 1955, over 600 beds,[12] and the contribution they made was invaluable.

Some welcome relief came in 1955, when at last an increase in capital funds for hospital building was announced.[13] Some major reconstructions and extensions were carried out at a number of hospitals, including Westgreen Hospital, Dundee and the Edinburgh Royal Mental Hospital. Separate accommodation was also provided for groups who, it was increasingly realised, required separation. The need for special reception or admission units to avoid bringing patients in the early and recoverable stages of mental illness into contact with the chronic and severely disturbed was acute. Some limited accommodation of this kind had been provided by inexpensive reconstruction , but in the latter part of the 1950s other units - including those at Aberdeen and Edinburgh Royal Mental Hospitals - were opened.[14]

More accommodation was also provided for those at either end of the age range. The National Health Service (Amendment) Act 1949 had, inter alia, enabled children under sixteen to be received as voluntary patients in mental hospitals on the initiative of their parents or guardians. The first childrens' unit in the NHS was opened - at the Crichton Royal - in 1951, and in the latter part of the decade further accommodation of this type was provided.[15] A limited amount of accommodation for elderly patients was also provided. There was a growing recognition that much could be done to arrest the development of mental disabilities associated with old age, particularly in special geriatric wards, and in the second half of the 1950s some progress was made in extending facilities for geriatric patients at

some hospitals, including Kingseat Hospital, Aberdeen and Stratheden Hospital, Fife.[16]

The break in the log-jam of financial stringency was especially welcome in the mental deficiency service. The extension of three mental deficiency institutions - Baldovan, Ladysbridge and Larbert - at a cost of £1,250,000 would, it was planned, create 850 new beds.[17] By 1957 these estimates had been revised, and it was expected that over one thousand new beds would be provided by the end of 1962.[18] Almost five hundred new beds were, in fact, by the end of 1957 almost ready for occupation,[19] and shortly afterwards work began on extensions to Gogarburn and Lennox Castle Institutions. But even with the projected new accommodation, desirable as it was, the number of mental deficiency beds would still fall short of the estimated need.

In many instances, the problem of accommodation was compounded by the equally difficult one of a shortage of medical staff, at both senior and junior level. In the later 1940s, considerable time and effort was devoted to the grading of hospital medical staff by Review Committees. The medical superintendents of large mental hospitals were normally accorded full specialist status and graded as consultants, and so, too, were some of their deputies, but in the case of some smaller mental hospitals full specialist status was not thought to be justified.[20] By 1949, seventy-eight psychiatric specialists - forty-four of them at the lower grade of senior hospital medical officer - were working in N.H.S. institutions, a number which was considerably lower than that in other specialities such as general medicine and general surgery.[21] This to some extent both reflected and encouraged the generally lower prestige - in the eyes of the public and of some of their colleagues - of psychiatrists; not

only were there fewer specialists in psychiatry than in medicine and surgery, but a larger proportion of them were on the S.H.M.O. grade.[22] If psychiatry was disadvantaged at the upper end of the scale, then there were also problems at the lower end, where there was a shortage of junior medical staff. The status of psychiatry, and the working conditions in many mental hospitals, did not encourage recruitment, and although there was some improvement in the mid-1950s,[23] particularly at senior level, the situation remained serious.

And even as the number of doctors increased, so, too, did the demands made on them. The expanding treatment programme within hospitals, but especially the growth of the extra-institutional sector, meant that the requirements of the service were developing more rapidly than the number of doctors. There were two areas where the pressure was particularly great. The first was out-patient clinics, where the number of those attending, and the number of attendances, was growing ever larger.[24] The second was that of domiciliary visitation; in the two years from 1955 to 1957, for example, the number of annual visits made by psychiatrists rose by almost nine hundred.[25] The extent to which the mental hospital was ceasing to be the sole setting for psychiatric treatment was hailed as a progressive step, but it placed an ever-heavier burden on over-stretched medical staff.

Mental deficiency institutions were in an even more difficult position. They were, in general, regarded as less appealing places to work than mental hospitals. Doctors did not have the satisfaction of performing their traditional role as healers - indeed, the institutions were not even called hospitals. Much of the work was monotonous, and the essentially static nature of the institutions was

thrown into sharper relief as the mental hospital atmosphere became more vigorous and optimistic. Further, mental deficiency work was not only outside the mainstream of medicine, but was even isolated from psychiatry, and as a consequence its prestige was low. The Scottish Health Services Council's 1957 report on mental deficiency suggested ways in which the gap could be bridged; it recommended the introduction of a system of registrarships which would require rotation between mental hospitals and mental deficiency institutions, and suggested that mental deficiency experience should be regarded as an important additional qualification for attaining consultant status. The burden on doctors, it believed, could be eased by delegating more routine work to non-medical staff.[26] In the meantime, however, some institutions found recruitment almost impossible.

The shortage of medical staff, then, particularly in mental hospitals and mental deficiency institutions situated away from large towns and university centres, remained acute; indeed, in a few cases, the position was so desperate that hospitals were forced to use general practitioners as part-time members of staff.[27] By 1960, the number of doctors was still well below the number required.[28] Nor was there much prospect of any improvement in the near future, for although it was possible that there might be a reduction in the number of patients entering hospital, the strain imposed by outpatient and domiciliary work seemed likely to increase still further.

The institutional service - both mental hospitals and mental deficiency institutions - also continued to suffer from the perennial problem of a shortage of nursing staff. The inauguration of the N.H.S. had not removed the factors which made mental hospital work the least attractive to the potential nurse. The physical environment of the

mental hospital offered little inducement; many were old and geographically isolated, some were drab and uninviting. The status of mental nurses was - perhaps because of the status of their patients, and because of their history as custodial 'attendants' - low, and mental nurses were isolated from the main body of the profession. There was some improvement in the nursing position in the late 1940s and early 1950s, but it seemed unlikely that, in the short term and under existing circumstances, recruitment would be significantly increased.

The seriousness of the situation convinced the Secretary of State to ask the Scottish Health Services Council to frame proposals for improving staffing. The ensuing report, issued in 1953, suggested ways in which new recruits could be attracted, and retained. It recommended that mental hospitals should review their existing personnel practices, and stressed the importance of initiating recruits into the life and work of the hospital. It recommended better planning of duty rosters, and improved study and recreational facilities, although it did not support an increase in the existing pay differentials between general and mental nurses to make mental nursing more financially attractive. Most importantly, perhaps, it suggested ways in which the isolation of the mental nurse could be broken down; it recommended that a combined training which would qualify the nurse for both the General and Mental Register should be instigated.[29] The profession considered these proposals.

Mental deficiency institutions offered the least opportunity for nursing in the generally accepted sense. According to another Scottish Health Services Council Report (on the non-medical staffing of mental deficiency institutions (1954)), many were understaffed,[30]

even though the employment of auxiliary staff was common and many institutions employed untrained nursing assistants.[31] One employed nursery governesses: women who assisted teachers with educable pupils and helped on the wards with the younger children. Their work was widely praised, and the S.H.S.C. recommended that more institutions should employ them,[32] but although auxiliary staff relieved some of the burden on qualified nurses, it was doubtful whether they fully compensated for their lack.

Various measures were taken in the 1950s to improve the situation. In the belief that ignorance was partly to blame for poor recruitment, short courses were arranged to familiarise Ministry of Labour Appointments Officers with modern mental nursing,[33] and intensive publicity campaigns were also undertaken, though the results sometimes were disappointing.[34] In an effort to bring mental and general nursing into closer association, some hospitals, like the Crichton Royal, allowed general nurses to take their mental qualification in a shorter time than was normally required.[35] A more significant step forward was taken in 1957 when an experimental scheme of training was introduced at Bangour General Hospital which provided a four-year course of dual mental and general training, the first of its kind in Scotland.[36] Some of the developments taking place within mental hospitals - including the up-grading of accommodation, new drugs which made patients less 'refractory' and the beginnings of the concept that hospital staff were all members of a team - made some mental hospitals more pleasant places to work. Nevertheless, the mental health service continued to experience more difficulty in recruiting and retaining nurses than did the general health service.

The shortage of staff and accommodation adversely affected the

quality of life of many mental defectives. Some who urgently required institutional care were simply unable to obtain it. Others were sent to mental hospitals, even though it was over forty years since the 1913 Act had made provision for mental deficiency institutions; and in the circumstances the General Board's comment that it was undesirable but unavoidable seemed rather restrained.[37] The problems of the service also affected those who did find an institutional place. The accommodation was often old, badly designed and lacking in adequate sanitary arrangements. In some cases, adequate classification was impossible and in many cases facilities for training, occupation and recreation were unsatisfactory.

It is, given these circumstances, unsurprising that little therapeutic innovation was possible in mental deficiency institutions. While the nature of mental deficiency made the expectation of recovery unrealistic, the conditions in the institutional service meant that the patients' improvement, which was possible, was rendered very difficult. The sheer lack of amenities and staff was compounded by the fact that because of the shortage of beds, only the most severe cases, with their limited potentialities, could be admitted. Isolated progress was made - the General Board praised, in particular, the sensory training which was developed at Lennox Castle[38] - but speech therapy, which could play such a valuable part in the 'normalisation' of the defective, and physiotherapy, which was so important for those with mental and physical disabilities, were both hampered by a lack of facilities and staff.

(ii) New methods and therapies

However, if there was little room for therapeutic optimism in

the mental deficiency service, the same was not true of the mental hospital service. Despite its problems, the post-war institutional service for the mentally ill was marked by an upsurge in new methods and treatments. Some of these therapeutic experiments were treatments in the generally accepted sense. But some of the most important developments were innovations in which the frame of reference was the environment or culture of the institution as a whole rather than the individual.

The 1940s and 1950s were marked by a more explicit recognition that the structures within which treatment took place were as important - perhaps even more important - than the treatment itself. This was not a new discovery; the nineteenth-century moral managers had stressed the impact of the asylum 'milieu' on the patients within it. In the years which followed, however, the emphasis placed on individual treatments - psychological and physical - meant that it was, to a large extent, forgotten, and the hospital structures became little more than a backdrop for treatment. In the post-war period, however, there was a reawakening of interest in the concept that hospital structures themselves had a directly therapeutic or anti-therapeutic effect. It was stimulated partly by work which seemed to show the negative impact that the traditional mental hospital could have on long-stay patients. 'Institutionalisation' or 'institutional neurosis' - which had, in the previous century, been called 'asylum-made lunacy'[39] - began to cause concern. There was also a growing recognition of the positive role that 'therapeutic' mental hospitals could play. There was a growing realisation that the hospital structure and environment was not merely the setting for treatment but was actually a part - and a major part - of the treatment, and that it

determined not only the well-being and comfort of the patients but, as the General Board recognised; 'possibly even their recovery'.[40] 'Administrative therapy', in the forms of the open-door and the therapeutic community, became a significant part of Scottish psychiatric theory and practice.

The term 'open door policy' has been used in various ways. It is sometimes seen as a corollary of the therapeutic community,[41] while in other cases it has been linked to a policy of encouraging voluntary admissions, and a reliance on out-patient care.[42] The policy was associated with these developments, but in this context the term is used, in the simplest sense, to denote the policy of unlocking doors within mental hospitals, and between hospitals and the outside world. Unlocked doors were not new; in the nineteenth century some Scots asylums had unlocked or 'open' wards, and one or two hospitals may even have been completely open.[43] Nevertheless, many had subsequently been closed again, until, in the years after the war, new ideas came in, or old ones were rediscovered.

There was no single reason for the development of the open-door policy. It cannot be directly attributed to any legislative change, since the beginning of the process was apparent before the N.H.S. was created. The N.H.S. may, however, have been one of the factors which contributed to its spread, since patients treated under it may have been less prepared to tolerate what appeared to be largely unnecessary restrictions on their freedom of movement. Nor can the open-door be specifically ascribed to the development of new therapies; at the time it began, the main physical treatments had been in use for some time, and its introduction preceded the widespread use of the major tranquillisers. Again, however, physical treatments may have

fostered the expansion of the system; E.C.T., in particular, became more refined and more widely used during and after the war, while the new drugs of the 1950s allowed even psychotic patients to share in the open-door system. Finally, it also seems likely that the open-door was linked with the continued increase in the number of voluntary patients.[44] More admissions of those with the relatively mild mental illnesses, who were free to leave the hospital if they chose to do so, made the lack of freedom within the hospital itself more incongruous. The unlocking of doors was, in one sense, the next logical step along the road which had already seen a large reduction, almost the virtual abolition, of restraint and seclusion - or the straitjacket and solitary confinement. That it took place when it did was, perhaps, the result of the subtle change in patients' status which occurred when many of those treated were no longer subject to compulsory detention.

In Scotland, the open-door policy is almost synonymous with Dingleton Hospital, Melrose. It is generally accepted as the first completely open-door hospital in the world, or at least in the English-speaking portion of it, in the twentieth century.[45] Its position as the originator of the policy was largely due to the initiative of the Superintendent, George Macdonald Bell. Dr. Bell had, simply, 'always hated having to lock people up',[46] and decided, at an early stage of his career, to either leave psychiatry or change it. His opportunity to change at least a small part of it came at Dingleton in the 1940s, and the last door in the hospital was opened in 1949. After that, all patients had complete freedom from locked doors throughout the hospital, including the exits.

However, the ensuing struggle to make sure that Dingleton's

doors stayed open was a microcosmic example of the difficulties that other superintendents also faced. The local community was at best suspicious and anxious, and at worst hostile. Dr. Bell spent many hours with the local police, the bailies, the provost, lawyers and townspeople, cajoling and explaining, and had to appear in court to account for the freedom given to patients who had subsequently broken the law. It took time, too, to win over his own staff.[47] Perseverance, however, paid off and, in time, some local people at least were proud of the 'unique reputation' of 'their' mental hospital.[48] Its fame was, indeed, international and, during the 1950s, psychiatrists from many countries visited the small Border town, and staff were seconded from English hospitals to study Dingleton's methods.

However, in an apparent illustration of the cliché that a prophet is without honour in his own country, the number of Scottish mental hospitals which followed Dr. Bell's lead was small. There is conflicting evidence as to how many actually did. In 1954, the Crichton Royal Hospital was included in a list of those which had adopted the policy,[49] but in the same year the Deparment of Health named the one-hundred-bed Gowrie House, Dundee and Dingleton as the only completely open-door institutions in Scotland,[50] and, by 1958, the General Board stated that there was only a single one.[51] Some of this apparent discrepancy may be the result of differences of definition.[52] But what is clear is that, despite its apparent and widely recognised success, Dingleton's example was not generally copied.

Some reasons for this can be suggested. Dingleton may have had advantages which other Scottish mental hospitals lacked. The temperament of the initiator seems to have been one of them. Dr. Bell was

described by his successor, Maxwell Jones, as being prone to unilateral decisions and as showing 'little or no tendency to bring about decision-making by consensus'.[53] While this is an implied criticism, such an attitude may, in the context of the open-door, actually have been necessary. It would certainly have been difficult for a less forceful personality to resist the internal and external pressures to back down. Dr. Bell also had a further potential advantage; Dingleton was, with four hundred beds, a relatively small hospital and when he opened the doors in 1949 he knew all the patients personally.[54] In a larger mental hospital, where the superintendent was more remote from the patients, the unlocking of doors was necessarily more of a leap in the dark. Most Scots superintendents were therefore either unconvinced of the desirability of a completely open-door system, or were unwilling to face the problems it entailed. Significantly, the General Board did not attempt to influence them, believing that the question of a 'reasonable balance' between freedom and security was a matter for individual hospitals to decide.[55]

Completely open-door hospitals, then, remained uncommon. But a diluted form of the system was widely supported, and doors which had previously been locked were opened until, by 1958, the General Board could state that closed wards were very much in the minority in every hospital.[56] The effects of what appeared to be the simple act of unlocking doors were far-reaching. Far from increasing disruption, it appeared to encourage a change in the behaviour of many patients, who were reported to be much more contented. The fact that the custodial role of the hospital staff was much reduced, or even eliminated in some cases, helped to promote a more cordial and relaxed hospital atmosphere.[57] The impact of the example of Dingleton Hospital was

still widely felt; it proved that a completely open system was possible, and provided a model towards which other institutions might aspire. Surprisingly this fairly small and rural hospital was also to be at the forefront of another form of administrative therapy - the development of the therapeutic community.

The 'founding father' of the concept of the therapeutic community, Dr. Maxwell Jones, was a Scot, who developed it as a result of his experiences with ex-prisoners-of-war and the long-term unemployed in London in the 1940s.[58] Jones and his disciples stressed the negative effect that the traditional hierarchical hospital structure had; by doing everything for the patient and by preventing him or her from thinking and acting as an independent person, the mental hospital encouraged passivity. The therapeutic community aimed to invest patients with increased responsibility by making the hospital structures more democratic and egalitarian. There was, as Jones pointed out, no one model of the therapeutic community,[59] but almost all of them shared certain characteristics. Constant efforts were made to open the channels of communication, and frequent staff and community meetings, at which experiences were discussed and criticisms and suggestions voiced, were normally held. There was, too, an emphasis on providing learning experiences through work and recreation. Attempts were made to 'flatten the authority pyramid',[60] and to blur hierarchical distinctions; multiple leadership and decision-making by consensus were the goals.

There is no doubt that there was increasing.interest in the therapeutic community concept during the 1950s. The General Board and the Department of Health both used the term frequently in the latter part of the decade. The Department believed that there was a

developing recognition of the mental hospital as a community in which all the staff, and the patients, played their parts as members of one team, while the Board felt that therapeutic community concepts were 'accepted and encouraged' by most mental hospitals.[61] Hospitals, it was claimed, stressed 'the patient's individuality, sense of responsibility and initiative'.[62] There was, indeed, some evidence of this; the opening of the channels of communication was at the core of the therapeutic community concept, and there was a growth in the use of group discussions and group social therapy in the 1950s.[63] The desire to give patients more responsibility, too, was reflected in the development of practical occupational therapy and work therapy with cash incentives, and in the extent to which patients began to organise their own recreation.[64] More emphasis on the patient's individuality can also be sometimes detected in such seemingly trivial events as the opening of patients' beauty and hairdressing salons.[65]

However, these trends did not, by themselves or even in combination, constitute any widespread shift towards therapeutic community hospitals. While the General Board and the Department of Health believed that the therapeutic community was welcomed by mental hospitals, it appeared that some hospital staff were not very familiar with the concept. While Dingleton Hospital, for example, had begun to initiate a more democratic approach, Maxwell Jones found, on his arrival there in 1962, that the junior staff knew 'little or nothing' of therapeutic community ideas.[66] Senior medical staff, who knew something of the concepts, lacked the 'know-how' to implement them.[67]

Other factors, too, militated against the general acceptance of the concept of the therapeutic community. The traditional hierarchical

structure of mental hospitals could not easily be broken down. The differences in status between senior and junior medical staff, and between medical and nursing staff were, in terms of the qualifications required and the salaries paid, tangible; perceptions of their proper place in the scheme of things, and of the role of patients, was difficult to change. It was particularly difficult to topple the superintendent from his entrenched position at the pinnacle of the hospital structure, however much he himself might desire to be a catalyst rather than a dictator. While the superintendent might preach collective leadership and consensus decisions, statutorily 'the buck stopped' with him; it was the superintendent who was bound to notify the admission of cases, review the detention of certified cases and, normally, discharge them. In these circumstances, it was inevitable that many directions and decisions would still have to be channelled through him. Mental hospitals, however egalitarian, still had a formal head.

Moreover there were less concrete barriers to change as well. It is impossible to generalise about the reaction of patients, staff and others to the therapeutic community concept, but a detailed account of the impact of change on one hospital - Dingleton - has been given by Maxwell Jones.[68] It was in many ways a painful process. Staff, though unhappy with existing procedures, in many cases felt threatened and undermined by the movement away from rigid demarcation, and the distribution of decision-making was not always popular. Patients - particularly the chronic and geriatric - were sometimes too helpless or dependent to take an active part, while those who did sometimes felt confused and angered by the demands of personal responsibility. The Hospital Management Board, and the South-Eastern

Regional Hospital Board, though often supportive, were not convinced of the merit of all Jones's innovations, and local general practitioners seemed unhappy. The local community, which had already gone through the trauma of the open-door, were wary, and a negative image of the hospital was fostered by the - apparently unfounded - rumours of sexual misbehaviour by patients and staff. It is unlikely that all therapeutic community hospitals faced the same problems, and despite internal and external difficulties Dingleton continued to operate on therapeutic community lines. Nevertheless, the insecurity and bitterness that the introduction of the new regime could cause meant that, as in the case of the open-door, a considerable amount of bravery and perseverance was required, on the part of all concerned, to implement it and see it through.

The relationship between the two main forms of administrative therapy - the open-door and the therapeutic community - is a complex one. Butler argues that they were 'not only incompatible approaches but [were] antagonistic in their ideals and organisation',[69] while Clark contends that they were interdependent, and that the administrative therapist who developed one usually found himself involved with the other.[70] The fact that Dingleton, a relatively small hospital in a predominantly rural community, was at the forefront of both policies might suggest that there was some link between them. In fact, however, when Dr Jones arrived at Dingleton, at a time when all doors had been opened for thirteen years, he found a hospital run on largely hierarchical lines. It may be, then, that the personal qualities which had created the first open-door hospital were unsuitable for the more co-operative approach which, after the initial 'push', was required to sustain the therapeutic community concept.

However, the open-door and the therapeutic community did share many features. Both were based on investing patients with more responsibility: in one case, that of deciding whether to remain in hospital or walk out of it, in the other, the responsibility that derived from being a participating member of the therapeutic community. Both aimed to break down barriers - whether physical (locked doors), or non-physical (established status) - between the patient and personal responsibility. Both made new, and sometimes difficult, demands on patients, staff and the local community. Both were more admired than imitated. Both, too, stressed the importance of activity for patients, and helped to stimulate interest in the new forms of occupational and work therapy which developed in the 1950s.

A well-established form of therapy, occupational therapy, continued to expand and develop in the post-war period. The extension of O.T. in the late 1940s and 1950s was stimulated by the part it had to play in the rehabilitation of post-operative leucotomy patients, and by the enhanced role of the occupational therapist as a member of the therapeutic team of the hospital 'community'. Occupational therapy increasingly began to come out of the O.T. department and into the wards. There was also a shift in its emphasis. It became more specifically geared towards resocialising the patient into the community and, as a result, O.T. of a directly practical nature became popular during the 1950s. As a corollary, incentive payments - either in cash or in kind - were increasingly given for the work done.[71] The fullest use of O.T., however, continued to be restricted by personnel shortages; although there were 150 occupational therapists employed in the hospital service as a whole by 1960,[72] there was still a shortage of trained therapists in mental hospitals.

An off-shoot of occupational therapy, 'industrial therapy', was also introduced. It involved the hospital accepting orders for work from companies, which the patients would then fulfil. It was not entirely new - in 1945, the Edinburgh Royal Hospital had arranged to make children's toys for a local firm[73] - but became more widespread in the 1950s. It was, however, a considerable departure from traditional occupational therapy; whereas, in occupational therapy, the economic value of the work was a minor consideration, this was an integral part of industrial therapy. It had both advantages and disadvantages as compared with ordinary O.T. Patients did 'real' work and, while they did not get 'real' wages, they at least had an opportunity to make extra money, which was especially important for long-stay patients who were often chronically short of it. The fact that outside firms were involved may have lessened the feeling of complete dependence on the hospital, and the patients had the opportunity for work which was at least related to work in the outside world. But there were also considerable drawbacks. The tasks undertaken - threading labels, addressing envelopes, and sorting wool, for example[74] - were almost invariably repetitive and frequently extremely monotonous. It certainly offered nothing like the individual satisfaction and opportunity for creative expression that traditional arts and crafts-based O.T. could. Above all, perhaps, it had the potential to be the crassest form of commercial exploitation of the mental patient. The extent to which an element of exploitation was avoided depended upon the staff involved, and the extent to which they selected the most interesting and sociable of the contracts offered by interested firms.

The 'night hospital' system, which was also introduced in the

mid-1950s, was a further step along the road to real work, and was the most advanced form of hospital employment. Under it, patients went out of the hospital each day to work for an outside employer, returning to sleep within the hospital walls at night. Patients normally received standard rates of pay, and were expected to make some contribution for their maintenance. Again, it was a bridge between the hospital and the outside world, and a means of rehabilitating the patient back into society. But although it was extensively used in a few hospitals - by 1958, more than fifty patients in one hospital went out daily to work on neighbouring farms[75] - the total number of patients involved remained small.[76] The extent to which it could be extended largely depended upon the employment opportunities available in the vicinity of the hospital, and on the continuation of full employment.

Not all therapies, however, were based on practicalities. Some hospitals discovered - or rediscovered - recreational therapy. Organised recreation had, as far back as the nineteenth century, been a feature of many mental hospitals, but it had been largely superseded by more sedentary occupations. In the mid-1950s, however, there was a revival of interest in more active recreation. A number of hospitals introduced - or re-introduced - physical training and team games, and some arranged training for the nurses who organised them.[77] Less strenuous pursuits were also introduced - in one hospital, a series of further education classes were held under the auspices of the local education authority.[78] There were differences between recreational therapy and nineteenth-century recreation - patients from all social classes took part, and they not infrequently helped to organise the recreation themselves. Nevertheless, the extent to which forms of

recreation popular generations before were rediscovered and even greeted as innovations was another illustration of the cyclical nature of policy.

These new forms of work and recreation did not, however, supplant traditional forms of hospital work. But one aspect of it - work on the hospital farm - was becoming less important. In the mid-1950s, the Government introduced the somewhat controversial policy of selling off farms which were not essential to the running of the hospital,[79] and, while it may have made mental hospitals less self-contained communities, it reduced, to some extent, the opportunities for work. Work in the hospital grounds, wards and kitchens, however, continued to be important; a survey of Scots mental hospitals and mental deficiency institutions in 1959 found that around one-third of the total patient population was engaged in 'useful' work within the hospital, for which they were rewarded, and, despite the introduction of industrial therapy, the majority still worked on traditional lines.[80]

One aspect of the changes which took place in the 1950s - the improvements made in the interior condition of mental hospitals - has sometimes received little attention. But although the upgrading of the fabric of the institutional service was not a 'therapy' in the usual sense of the term, it was, the General Board believed, at least as important as those innovations, and was even 'the most important single advance made in the mental hospital service in recent years in so far as it immediately affects patients well-being and welfare'.[81] The easing of financial constraints undoubtedly encouraged the changes which took place. But there was also, perhaps, a new sense that patients were entitled to better conditions and a new recognition

- which was also reflected in the administrative therapies already described - that environment played a major part in recovery. Reconditioning was also a means of making mental hospital work more attractive to staff, or potential staff.

For a combination of reasons, then, the second half of the 1950s was marked by a spate of internal modernisation, redecoration and refurbishment. Voluntary effort also co-operated in the improvement of amenities, with hospital leagues of friends providing television sets and reading material, and running canteens for patients. Progress was uneven and, in some hospitals, slow. The General Board found the contrast between renovated hospitals, or parts of hospitals, and the remainder disturbing, and it acknowledged that much still remained to be done; kitchen and sanitary facilities, in particular, still in many cases fell far short of acceptable modern standards.[82] Nevertheless, there had been an improvement, amounting in some cases to a transformation, in patients' surroundings. The lighter, brighter, less 'institutional' appearance of some hospitals can only have had a positive effect on the well-being of patients, the perceptions of visitors, and the morale of staff.

Significant advances in chemotherapy were also made during the 1950s. Despite the new methods of treatment which had been introduced in the inter-war period, schizophrenia and manic-depressive illness were still responsible for an enormous amount of serious mental illness.[83] In the 1950s, however, new drugs were introduced to fight these psychoses. These were the phenothiazines, generally called the 'major tranquillisers', the most important of which was chlorpromazine (Largactil). It was developed following tests to find a new drug for anaesthetic and shock prevention purposes, and its application to the

sedation of agitated psychiatric patients was one of the first of its uses to be explored. The results, however, suggested that as well as its calming effect, which made it particularly suitable for those in the manic stage of manic-depression, it specifically relieved the most disturbing symptoms of schizophrenia. In 1954 reports of its dramatic effects began to appear in psychiatric journals and, shortly afterwards, it was introduced into Scottish mental hospitals.

The results were encouraging. In a large proportion of psychotic patients the major tranquillisers produced a significant and at times 'dramatic' amelioration of symptoms.[84] Chronic, long-stay patients were, in some instances, improved to the extent that they could once again become 'participating members of the hospital community', or even be discharged if home circumstances were appropriate.[85] There were, almost inevitably, side effects. Parkinsonian rigidity and 'restless legs' were the most common, but they were treatable and temporary and ceased when the drugs were discontinued. But the tardive dyskinesia - continual working of the jaw and mouth - which sometimes occurred after prolonged treatment was not, in all cases, reversible.[86]

The new drugs, then, were 'not free from complications'.[87] It was partly for this reason that the Department of Health and the General Board remained notably cautious about the role of drugs. They were determined not to accept them uncritically, and pointed out that they provided 'symptomatic relief' rather than a cure,[88] and that they frequently had to be used in combination with other forms of treatment. Nevertheless, despite these reservations, the major tranquillisers and E.C.T. - used either separately or in combination - had by the late 1950s become the mainstays of the physical treatment of schizophrenia

Table 9:1 Annual Admissions to Mental Hospitals, 1947-60

Year	Voluntary	Certified	Total
1947	2760	2379	5139
1948	3156	2608	5764
1954	5862	2649	8511
1955	6585	2583	9168
1956	7415	2732	10147
1957	8272	2747	11019#
1958	8802	2653	11455
1959	9977	2451	12428
1960	10462	2298	12760#

Excluding admissions to the State Mental Hospital

Source: Annual Reports of the General Board of Control for Scotland

* There are discrepancies between the statistics provided by the General Board and those of the Department of Health, particularly in respect of compulsory admissions. Moreover, the Board does not always make it clear whether the statistics include admissions to the State Mental Hospital; only the figures for 1957 and 1960 definitely exclude these admissions.

and manic-depressive illness. They had to a large extent replaced the more drastic options of psychosurgery and insulin-coma therapy; very few leucotomies were being done by the end of the decade, and insulin treatment was only used, in a few hospitals, for cases of schizophrenia which proved resistant to anything else.[89]

(iii) The new dynamism

What, then, were the combined results of the new drugs and of the other changes? Perhaps the single most significant development which occurred in the period 1948-1960 was the extent to which mental hospitals were becoming more dynamic. Firstly, and at the most basic level, more and more patients were entering hospitals. In 1938, over three thousand patients were admitted to Scottish asylums; ten years later the figure was well over five thousand. By 1954, it had increased to over eight thousand and during 1960 over twelve thousand patients were admitted to mental hospitals.[90]* It is possible, of course, that this extraordinary rise was simply the consequence of an increase in mental disorder in the community, and it is certainly difficult to prove that it was not. Nevertheless, the numbers involved were so large that it would have taken an unprecedented explosion of mental illness to account for them. On balance, then, it seems likely that factors other than any astonishing increase in mental disorder were involved.

One of these other factors was demographic changes. The incidence of mental hospital admission showed a steady climb from chidhood onwards, and the elderly were many times more likely to be admitted to a mental hospital than those in the younger age groups.[91] Since the proportion of elderly people in the community was rising,

*90 Table 9:1

an increase in total admissions was to be expected. Again, however, the ageing population could hardly explain a doubling of the number of admissions in the twelve years from 1948-1960, particularly when many of the elderly were admitted as certified patients.[92] For it was, crucially, an increase in the number of voluntary admissions that was responsible for almost all of the total increase; the number of certified patients admitted annually remained virtually static.

The increase in the number of voluntary admissions, and in the proportion of total admissions which were voluntary, was dramatic. The number of patients entering mental hospitals on a voluntary basis rose from just over one thousand in 1938 to over three thousand in 1948, to nearly six thousand in 1954, and to over ten thousand in 1960. Just before the war, about one third of all admissions were voluntary. In 1948, more than half of all admissions were voluntary. By 1954, more than two-thirds were voluntary, and by 1960 voluntaries accounted for more than 80 per cent of all admissions.[93]*

The crucial question, therefore, is not so much why the number of admissions increased, but why the number of voluntary admissions increased. The most obvious explanation is that more people were willing to enter hospital of their own accord. No one factor can, by itself, account for this, but the advent of a free National Health Service undoubtedly played a major part. It not only gave poor patients the same opportunity for early and voluntary treatment as the better-off,[94] but may also have contributed to the more tolerant public attitude towards the mentally disordered which was widely remarked on.[95] It is very difficult to demonstrate that such a shift in attitudes was taking place - indeed, the most convincing 'proof' that it was was itself the rise in voluntary admissions - but it seems

*93 Table 9:1

Table 9:2 Re-Admissions to Mental Hospitals, 1959 and 1960*

Year	Period Since Previous Discharge	Number of Patients	% of Total Admissions
1959	Less than 3 months	1139	9
	3-6 months	886	7
	6-9 months	624	5
	9-12 months	365	3
	More than one year	1466	12
	Total	4480	36
1960	Less than 3 months	1365	11
	3-6 months	872	7
	6-9 months	632	5
	9-12 months	517	4
	More than one year	1726	13
	Total	5112	40

Source: Annual Reports of the General Board of Control for Scotland

* It is not clear whether these statistics include the State Mental Hospital.

likely that it was at least partly responsible for the apparently greater alacrity with which patients entered hospital. It may also have had a 'snowball' effect, since the community's growing tolerance, which encouraged admissions, may, in turn, have been further increased by the fact that so many mental patients were not certified and subject to judicial detention.

It is similarly difficult to separate cause and effect in respect of the changes which took place in mental hospitals, particularly during the latter part of the 1950s. The development of the open-door and the concept of the therapeutic community, the growth of new forms of work and recreation, and the improvements made in decoration, tended to make mental hospital treatment a less unpleasant prospect for patients, while the new status of many of the mental hospital population may, in turn, have encouraged these developments. The General Board, among others, also believed that improvements in existing methods of treatment, and the development of new ones which appeared to offer a better chance of cure, encouraged patients to enter hospitals.[96]

There was, however, a further reason for the increased number of admissions - the incidence of re-admissions. Patients who were admitted to hospital twice, or even more, within the space of one year, appeared in the annual admission statistics more than once.[97] During the post-war period, the number of re-admissions, and the proportion of total admissions which were re-admissions, was growing; indeed, in the space of one year, between 1959 and 1960, the percentage of those entering mental hospital who had been there before jumped from 36 to 40 per cent.[98]* The trend began to cause concern, and in 1959 the General Board was disturbed enough to undertake a

* 98 Table 9:2

Table 9:3 Discharges from Mental Hospitals, 1948-60*

Year	Voluntary	Certified	Total
1948	2590	1207	3797
1954	5145	1256	6401
1955	5718	1481	7199
1956	6349	1650	7999
1957	7197	2071	9268#
1958	7624	1812	9436
1959	8719	1935	10654
1960	9008	1966	10974

Excluding discharges from the State Mental Hospital

Source: Annual Reports of the General Board of Control for Scotland

* It is, with the exception of 1957, not clear whether these statistics include discharges from the State Mental Hospital.

special investigation into it. Two factors stood out; voluntary patients were considerably more likely to be re-admitted than certified patients,[99] and a quarter of all admissions were of patients discharged less than one year before.[100]*

One of the reasons for this worrying picture was that the factors, already described, which made patients less reluctant to enter hospital applied to re-admissions as well. But the question of why, despite all the developments which had taken place in the service, so many patients <u>needed</u> to be re-admitted still remained. Relapse was, perhaps, to be expected in many cases since discharged patients often returned to conditions which may well have contributed to their illness in the first place. It was also, perhaps, evidence of the limited effectiveness of mental hospital treatment, although the General Board believed that some ex-patients contributed to their own relapse by failing to continue with their medication.[101] After-care and community support facilities, too, had, in many cases, not developed to the stage which was necessary to provide the back-up services which many discharged patients required.[102] But there was also a growing belief that some patients were re-admitted because they left hospital before they were ready to do so.

For mental hospitals also became more dynamic in the sense that the number of patients discharged each year grew. Most of the increase was due to the growth in the number of voluntary patients who left hospital annually, which was less than one thousand in 1938, more than two thousand in 1948, over five thousand in 1954, and nine thousand in 1960.[103]* Again, the reasons for this dramatic growth were complex. It was partly an inevitable consequence of the increase in admissions - since mental hospital accommodation was

*100 Table 9:2

*103 Table 9:3

finite, it was to be expected that the number of discharges would also rise. But a more vigorous discharge policy was also consciously sought as the dangers of a long stay in hospital, isolated from the community, became more apparent, and as an active discharge policy became a measure of progressiveness. The pursuance of more energetic discharge was also facilitated as amenities for after-care - including day hospitals and out-patient clinics - though still inadequate, became more widely available.

The increase in the number of discharges was also a consequence of voluntary status itself. Voluntary patients were, by definition, less seriously ill than certified patients, since they had not reached the certifiable stage. Many suffered from relatively mild neurotic conditions which did not require prolonged treatment. Further, voluntary patients, unlike certified patients, were - after giving three days notice and providing that they were not detained as being a danger to themselves or others - free to leave when they chose. Indeed, the increase in the total discharge numbers was not primarily due to an increase in 'discharges' at all, but to an increased number of patients leaving hospital, whether with or without official approval.

Finally, it is very difficult to evaluate the part played by new treatments - and particularly the major tranquillisers - in the increased number of patients leaving hospital. But it would be over-stating their role to attribute it wholly to their use; they were not introduced until the mid-1950s, when the acceleration was already apparent. The question of whether the trend would have continued if they had not been introduced is hypothetical. It is, in the end, impossible to isolate the various strands which contributed to the

enormous growth in voluntary discharges in the post-war period. It is certain, however, that it had a profound effect. By the late 1950s, about one-third of all voluntary patients who left hospital did so after a period of residence of only a few weeks, even, in some cases, after a few days.[104] It was this almost 'conveyor-belt' treatment which may have been a factor in the increasing number of re-admissions.

By the late 1950s, then, there were almost two mental hospital populations. The statistics of certified patients had shown relatively little change in the post-war period. Not only had the number admitted to hospital annually stayed relatively stable,[105]* but the numbers discharged each year, after showing an encouraging rise between 1948 and 1957, actually dipped in 1958.[106]* As late as 1956, about one-eighth of the hospital population - some 2,500 patients, the overwhelming majority of them certified - had been in hospital for thirty years or more.[107] These long-stay patients had, perhaps, more in common with mental defectives in institutions than with the short-stay, generally voluntary, patients who, by entering hospitals in larger numbers, remaining there only briefly and, in many cases, being re-admitted, were responsible for perhaps the outstanding feature of the institutional service in the 1950s, the more intensive use of mental hospitals.

* 105 Table 9:1

* 106 Table 9:3

Chapter 10 Extra-Institutional Services

(i) After-care

(ii) Community care

(iii) Voluntary effort in the welfare state

(i) After-care

The institutional developments described in the last chapter held obvious implications for the community mental health services. Rehabilitative services were needed for long-stay patients who, as a result of new drugs and other therapies, returned to the society from which they had been removed for years. But these were also necessary for the increasing number of patients who, as a result of the new dynamism of mental hospitals, left hospital after a short stay: adequate community care could not only facilitate discharge at an earlier stage, but might help to prevent the relapses which appeared to be associated with the faster turnover of patients. Ex-mental patients were therefore not a homogeneous group and did not have the same needs. A variety of services were needed for those who required relatively short-term support and for those who required longer-term and more intensive care.

After-care was most highly developed for patients discharged from the State Mental Hospital and State Mental Deficiency Institution. Suitable employment and lodgings were found for the patient prior to discharge and guardians - usually the patient's prospective employer, and a doctor - were appointed. When the patient was released - on probation or licence - close contact was subsequently maintained among the guardians, the medical staff from Carstairs and the General Board's after-care officer.[1] However, while effective after-care was particularly essential in the case of special patients, it was neither practicable nor necessary for such elaborate arrangements to be made in every case. Some help was, nevertheless, still required.

There were various provisions which could be used to help find employment for the mentally disordered. The Disabled Persons

(Employment) Act 1944 was designed to assist those who, because of injury, disease or congenital deformity, were substantially handicapped in finding suitable employment, but who were still capable of productive work of some kind. Under its terms, the mentally disordered could apply for registration as a disabled person, and it then became the duty of the Disablement Resettlement Officer of the Ministry of Labour and National Service (which was generally responsible for the Act's administration) to try and place them in suitable work. The mentally disordered were also entitled to take advantage of the Youth Employment Service, since the Employment and Training Act 1948, which established the service, did not draw any distinction between normal and disabled young people. The service, which was administered in some areas by the education authority and in others by the Ministry of Labour,[2] was responsible for providing those under eighteen with information about careers, helping them to find suitable openings, and keeping in touch with those it had placed; and in the case of the disabled it normally worked in co-operation with the D.R.O.

However, even in the 1950s, a period of relative prosperity and low unemployment, the Y.E.S. and the Disablement Resettlement Organisation found that difficulties stood in the way of their task of placing the mentally disordered in jobs. Discrimination against ex-patients probably played a part, but there were many practical problems too. The frequent lack of a social worker, almoner or other member of the hospital staff with detailed knowledge of the patient's capacities was 'a definite drawback' to placement.[3] A few hospitals attempted to remedy the situation - Craig Dunain Mental Hospital, Inverness, for example, in 1954 appointed a 'Vocational Adviser' to

give employment counselling and to liaise with the Disablement Resettlement Officer[4] - but such appointments were rare. There was a general lack of information and communication. There was a feeling that in many areas the Disablement Resettlement Organisation was not functioning properly because many patients were either unaware of its existence or were ignorant of their entitlement to use it. Inadequate liaison also meant that in some cases the D.R.O. had no knowledge of discharged patients.[5] The sparseness of hostel accommodation, and of other 'half-way houses' was also a problem. It meant that some patients who were capable of work but who required a more supportive environment than home conditions could provide could not take up jobs, while, in other instances, placements could only be made if patients were able to return to the institution each night.[6]

Provisions were also necessary for those ex-mental patients who could not return to normal employment. Two of the most innovative projects were developed by voluntary organisations. The Red Cross Treatment Centre , opened in Glasgow in 1945, provided day-care for approximately thirty ex-servicemen. Its most novel feature was that it catered for both the mentally ill and the physically disabled, and ex-mental patients with disorders ranging from neurosis to chronic schizophrenia were treated alongside the physically handicapped.[7] Todhill Farm Hostel, Kilwinning, on the other hand, was for mental defectives only. It trained patients who were on licence from institutions in agricultural work and, in the mid-1950s, had accommodation for about twenty patients.[8] Both these provisions were the first of their kind in Scotland - indeed, the Red Cross Centre was probably unique - and both demonstrated that voluntary effort could still lead the statutory sector in pioneering new forms of provision.

Experimentation with another form of after-care - the day hospital system, under which patients spent the day in hospital but returned home at night - began in the mid-1950s. Although in England some day hospitals were independent institutions, in Scotland day facilities were provided within ordinary hospitals, although some separate amenities were available in some cases. The Crichton Royal Hospital began a day hospital in 1954, and its lead was followed by a small number of other mental hospitals, including Ravenscraig Hospital and the Edinburgh Royal Hospital. In Glasgow a day hospital was opened in 1958 in association with the psychiatric department of the Southern General Hospital in Govan.

The number of day places provided was in every case relatively small.[9] Patients normally attended on five days a week and a wide variety of treatments were available to them; while there was generally an emphasis on occupational and work therapy, and on psychotherapy, physical treatments, particularly drugs, were also given. Many of those attending day hospitals were former in-patients who were discharged to the day hospital, but others had never been in a mental hospital. Day hospitals were therefore both a form of after-care and an alternative to mental hospital treatment for milder cases.

Day treatment, indeed, had several advantages over in-patient treatment, both for the hospital authorities and staff and the patient. It was, firstly, cheaper; since no beds were needed, and only one full meal was provided, costs were lower, and day facilities were generally provided without new staff.[10] It was particularly suitable for patients whose family responsibilities made residential treatment difficult. It enabled patients to maintain, or to re-establish at an earlier stage, family ties, and minimised the dangers

of isolation and institutionalisation. It may also have been less stigmatising, particularly when, as at the Southern General, the day hospital was situated within a large general hospital.

Day hospitals, however, could not perform all the functions of in-patient treatment. They were unsuitable for patients who were anti-social, dangerous or suicidal, for those whose families were unable to cope at evenings and weekends, and for patients who required specialised treatment such as deep insulin coma therapy. The location of the hospital could also make travelling to it for day treatment impracticable. Nevertheless, as a stepping stone for ex-mental patients and as an alternative to hospital for those who needed more than occasional attendance at an out-patient clinic, day treatment seemed the almost ideal compromise. In view of this, it is surprising that, during the 1950s, day hospital provision remained limited. It was, however, still at the exploratory stage, and, towards the end of the decade, some expansion of it was planned.

There was also a continued expansion of 'traditional' out-patient care in the form of psychiatric clinics in mental hospitals and psychiatric departments in general hospitals. In the 1950s, clinics were provided in some remote areas - including Stornoway, Lerwick and Kirkwall - which had not previously had them, and greater use was made of out-patient services generally.[11] There was still a large regional imbalance in facilities - almost half of the eighty-seven clinics which were in existence in the late 1950s were in the Western Hospital Region, while the North-Eastern and Northern Regions were relatively poorly served.[12] However, the easing of financial restrictions in the mid-1950s did enable some outstanding facilities to be provided, among them the Ross Clinic at Aberdeen Royal Mental

Hospital, which had an in-patient department and a day hospital as well as a diagnostic, advisory and treatment service for out-patients.[13] The Clinic therefore provided preventive and pre-hospital care, short-term residential treatment which was an alternative to ordinary hospital care, and after-care.

(ii) Community care

Clinics, out-patient departments and day hospitals straddled the boundaries between after-care and community care, but the hospital generally appeared somewhere on the treatment continuum of the patients they dealt with, and they were situated in hospitals. However, services of a different kind were needed for those, particularly mental defectives, who did not require institutional care or who, because of the shortage of beds, were unlikely to obtain it. This section describes the community services which were a more or less permanent alternative to institutional care, and discusses the common problems of the after-care and community care services.

Severely mentally defective children, and their parents, were, perhaps, in the greatest need of help, but only very limited progress was made towards providing it. One of the areas where the shortfall was greatest was provision for the under-fives. It was widely recognised that nursery provision - both day and residential - was urgently required. It could, at the very least, relieve hard-pressed parents of some of the burden. It could help the child to develop the most basic skills - of feeding and dressing himself - and perhaps even bring him up to the level where attendance at an occupation centre might be feasible later. It could also act as an observation and assessment centre which could assist in the diagnosis of the degree

of disability. Nursery provision, however, despite recommendations that it should be extended, was inadequate. In the 1950s, a few short-stay places for the mentally handicapped were provided in a few areas, including Edinburgh and Ayr.[14] But while children with severe mental deficiency were, through the child welfare and health visiting services, being discovered at an early age, the L.E.A. could not actually notify a mentally defective child to the local health authority as untrainable before it reached the age of five, and health authorities in most cases could offer little in the way of practical help to children below that age.

The provision made for mentally handicapped children of school age who were excluded from the education system was also unsatisfactory. Although the degree of disability of the 5-16 year-olds for whom local health authorities were responsible suggested that outside help of some sort was particularly necessary, local authorities did not generally provide any regular visitation or supervision for those who were not certified. Uncertified cases who, because of the acute shortage of mental deficiency beds, were awaiting admission to an institution were therefore often permitted to remain at home - sometimes in unsuitable conditions and in some instances for years - without any local authority care.[15]

Local health authorities were also responsible for providing suitable training and occupation for the lowest grade of juvenile defectives. But statutory provision of day-care centres for untrainable juveniles - which were, confusingly, also generally called junior occupation centres - was almost non-existent; by the late 1950s only one local health authority had provided such a centre.[16] A number of others were provided by voluntary bodies; a

few S.A.M.H-affiliated local voluntary associations - including those in Stranraer and Clydebank - and a number of local branches of the Scottish Association of Parents of Handicapped Children - including those in Glasgow, Airdrie, Sanquhar and Castle Douglas - conducted junior centres.[17] But there was undoubtedly a need for more. In many cases, severely defective juveniles who were statutorily excluded from the education system were unable to attend a local health authority or voluntary centre, and were denied the opportunity to develop fully their limited potentialities.

The domiciliary visitation of adult defectives who were not certified was similarly inadequate, and many local authorities did not make any provision for their supervision. In one or two urban areas, conscious efforts were made to improve the situation. In Dundee and in Glasgow, the local authority in the 1950s appointed an after-care officer who compiled registers of all special school and occupation centre leavers, undertook regular visitation and, in co-operation with the Youth Employment Officers, helped to find jobs for the defectives.[18] Such provisions, however, were rare.

Many local authorities also failed to fulfil their responsibility to provide, or to secure the provision of, suitable training and occupation for defectives over sixteen. By the mid-1950s, only three senior occupation or employment centres were directly maintained by local health authorities.[19] Again, the shortfall in statutory provision was, to some extent, compensated for by voluntary effort, and a number of S.O.C.s were provided by voluntary organisations with financial assistance from local authorities. Paisley and District Local Voluntary Association was particularly active. It opened a centre for female defectives at Kersland House in 1950, and in 1956

established a new 'occupation and recreation centre' for males at Monkshaw; significantly, the three L.H.A.s concerned made a substantial contribution to the Association's work.[20] S.A.M.H. affiliates in a number of other areas - including Ayr, Falkirk, Greenock, Cambuslang and Cupar - also ran senior centres,[21] and, towards the end of the 1950s, the Scottish Association of Parents of Handicapped Children extended its activities to their establishment.[22] There was also some expansion of local authority provision towards the end of the decade, and by 1959 eight local authorities had provided senior centres.[23]

The work done in senior centres, and particularly the emphasis laid on training and recreation respectively, varied, but the emphasis was generally on the inculcation of practical skills; indeed, in the late 1950s, some centres, in parallel with the trend in institutions, began to take work on contract from local firms.[24] The centres' role, however, was universally applauded, and it was recognised that they were an invaluable form of provision for lower grade mental defectives who had to leave L.E.A. or voluntary junior centres at sixteen and who were unlikely to hold down a normal job. However, it was equally universally acknowledged that there were not nearly enough senior centres. While the lack of information made precision difficult, all those involved in the mental deficiency service, and all those who investigated it, agreed that there was a pressing need for more, and that it was nothing short of 'tragic' that many mentally defective children who left junior centres unable to earn their livelihood by regular work were denied a senior centre place.[25]

The traditional form of 'community care' - the boarding-out or guardianship system - was also experiencing difficulties. The

Department of Health and the General Board were still convinced of its advantages, not the least of which was that it provided an alternative form of care for mental defectives at a time when institutional accommodation was in short supply. But the increased general prosperity of the 1950s had both a positive and negative effect on the policy. It meant that more relatives were able and willing to take care of their kin and were able to provide more material comforts. The other side of the coin, however, was that there was less of a financial incentive for guardianship and as older, unrelated guardians died, it became increasingly difficult to find new ones to take their place.[26] There was therefore a slight fall in the latter years of the 1950s in the number of mental defectives under guardianship.[27] In the case of the mentally ill, where institutional accommodation was not so scarce, the drop was more dramatic, and the number of certified mental patients in private dwellings halved between 1950 and 1960.[28]

The results of the new powers which local authorities had been given in the 1940s, then, had in general been disappointing. While some progress had been made, the overall picture was not encouraging. The obvious question is therefore: why were local authorities slow to develop community services for the mentally disordered?

The most obvious explanation was that local authorities were not statutorily bound to provide all the elements of a comprehensive community service. While section 27 of the 1947 Act empowered L.H.A.s to make arrangements for prevention, care and after-care, it did not require them to do so. Nor were local authorities obliged to provide welfare services for the mentally disordered; while the Secretary of State had, at an early stage, used his powers of direction to convert local authorities' functions in respect of the blind into duties, he

had not done so in the case of the mentally disordered. An element of compulsion did not, as the provision made for the training and occupation of defectives demonstrated, guarantee a satisfactory service, but the lack of any statutory obligation was, when combined with other problems, a potent deterrent to proper provision.

These other problems began at the most fundamental level. There was a chronic lack of accurate and up-to-date information, and, time and time again, those involved in local authority services were frustrated by the fact that such a basic question as the number of the mentally disordered who required the various provisions could simply not be answered. Thus, when S.A.M.H. tried to find out how many mentally deficient under-fives there were, it could not do so.[29] When local authorities were asked about the number of uncertified mentally deficient adults and children living in the community, many could not provide even a rough estimate.[30] When the number of defectives awaiting admission to institutions was sought, it could not be found.[31]

Inadequate ascertainment was undoubtedly part of the problem. The continued shortfall in the ascertainment of juvenile defectives by education authorities had a 'knock-on' effect on adult ascertainment. It was more difficult to discover defectives over the age of sixteen and local health authorities received little official encouragement to do so.[32] Even when a defective was discovered as a juvenile, however, gaps in the notification procedure meant that, in many instances, they disappeared from official view at the age of sixteen. There was also a problem with 'pigeon-holing' of those who were known. Information was, in many cases, not pooled; thus, while each Regional Hospital Board had a record of those awaiting admission to institutions, there was no central register. Some of the mentally disordered who required

local authority services were known to R.H.B.s, and others to welfare departments, general practitioners, local voluntary organisations, the D.R.O. and the Y.E.S., and it was as if each had a piece of the jigsaw but none had the complete puzzle.

This fragmentation of information was, to a large extent, a reflection of the deep-seated fragmentation of the administration of the service. The tripartite structure of the N.H.S. meant that conscious efforts had to be made to promote continuity of care, but in many cases there was a lack of co-ordination between the institutional service and those involved in community care. Further, responsibility for the provision of services for the mentally disordered living in the community was divided between Regional Hospital Boards, education authorities, general practitioners, local health authorities and welfare departments. In some cases, closely related functions were the responsibility of separate bodies; thus, while mental patients boarded-out under the Lunacy Acts, mental patients on pass or probation and mental defectives on pass or licence were maintained by R.H.B.s, mental defectives under guardianship were a local authority responsibility,[33] and the duty of providing occupation centres for juveniles was divided between education authorities and L.H.A.s. In many cases, too, there was little co-operation between the various statutory authorities and voluntary effort, with the statutory sector sometimes unaware of the services which local voluntary groups were providing.[34] All of those who investigated the service were convinced that more co-operation between all the bodies involved was needed, and various suggestions for the establishment of co-ordinating machinery were made. While measures were taken in some areas - where, for instance, the local authority's functions under the National

Assistance Act stood referred to the health committee,[35] or where R.H.B.s arranged for their maintenance duties to be carried out by the local authority acting as their agents[36] - there was still a pressing need for more integrated and comprehensive community services.

It was by no means just lack of information and co-ordination, however. One of the most important reasons for the inadequacy of community care - and especially of after-care - was the severe and chronic scarcity of trained psychiatric social workers, who had such an important role to play in it. Hospital psychiatric social work was generally considered to be more attractive than local authority work, but mental hospitals suffered from a shortage of P.S.W.s. Training opportunities were limited and recruitment was slow. Salaries offered little incentive and, despite Younghusband's assertion that the status and functions of hospital P.S.W.s were more clearly defined than those of P.S.W.s working in local authorities,[37] in some hospitals P.S.W.s were still struggling for proper recognition.[38] Even when hospitals were anxious to appoint P.S.W.s, they often had great difficulty in finding them.[39] In the mid-1950s, more than half of Scotland's twenty-seven major mental hospitals had no P.S.W. In others, part-timers were used or almoners did the work. Only seven hospitals had at least one full-time P.S.W.[40]

The local authority health and welfare services had even more difficulty in recruiting P.S.W.s. Local authority work was still a largely unrecognised career and most P.S.W.s employed by local authorities worked in child guidance. A mere handful of P.S.W.s were employed by local authority health departments by the end of the 1950s;[41] in one case, the local authority 'shared' a P.S.W. with a mental hospital.[42] The number was entirely inadequate to meet the

need for their services and as a result local authority mental health and welfare functions were often undertaken by those who had no special training and little time to devote to the mentally disordered.

Health visitors also played a role in the community care of the mentally disordered. The National Health Service Act which had, for the first time, prescribed their duties, envisaged that, in addition to their traditional role in maternity and child welfare, health visitors would, in future, include among their functions the giving of advice as to the care of those suffering from all types of illness, and on the measures necessary to promote health. Their extended functions were not confined to the services which local authorities provided, and it was expected that general practitioners and hospitals would be able to enlist their co-operation.[43]

In some cases, health visitors did begin to participate more in the mental health service. While they had an obvious role to play in the detection of mental abnormalities in early childhood, some also undertook the domiciliary visitation of the mentally disordered.[44] In the early years of the N.H.S., however, any major extension of their mental health work was hampered by a shortage of health visitors. It was not as acute as that of other local authority staff, but when it was coupled with an increase in their work with mothers and babies, and with the fact that many health visitors were also district nurses, it left health visitors little time for mental health work.[45] Some, indeed, doubted that they should do the work; the Working Party on Health Visitors 1956 report felt that it should be merely incidental to their traditional functions.[46] Most importantly, perhaps, health visitors' training did not really equip them to play their full role in the mental health service.

However, the shortage of health visitors eased during the 1950s, and mental health training for health visitors was provided in some areas, including Aberdeen, Dundee, and Edinburgh, where in 1959 the Royal Mental Hospital began in-service training for health visitors.[47] Shortly afterwards Glasgow University and the Corporation started a six-month full-time mental health course for health visitors, which included supervised practice in mental hospitals and psychiatric units.[48] Gradually, the role of health visitors began to diversify. Kirkcudbright County Council arranged for the health visitor/district nurse to co-operate in the after-care of ex-mental patients.[49] In Aberdeen, health visitors played an integral role in the City's mental health 'drive' of the late 1950s;[50] in Edinburgh, health visitors were attached to the new psychiatric out-patient department at Niddrie;[51] while in Glasgow mental health-trained health visitors were attached to local mental hospitals.[52] But although health visitors were increasingly finding a place in the community mental health service, their continued concentration on their traditional functions meant that, in general, mental health work was still fairly low on their scale of priorities.[53]

Underlying all these other difficulties, and the whole area of non-hospital care, was the inadequacy of the financial resources devoted to the services. The problem had two separate but inter-related aspects. The first was the degree of support which local authorities received from the centre. The situation in respect of welfare services was clear-cut; for most of the post-war period, welfare services did not qualify for grant aid from the Exchequer. It was not until 1958, and the Local Government and Miscellaneous Provisions (Scotland) Act, that a measure of Exchequer assistance to

local authorities in the development of welfare services for the handicapped was provided.

Expenditure incurred by an authority in the discharge of its functions as a local health authority did qualify for a grant at a uniform flat-rate of 50 per cent. In the stringent economic climate of the late 1940s and much of the 1950s, however, central government was extremely concerned to minimise expenditure. It therefore offered little encouragement to the development of community mental health services. Indeed, in some instances it virtually discouraged it; although the Scottish Advisory Council on the Welfare of Handicapped Persons' report on the mentally disordered was completed in 1955, it was kept 'under wraps' for two years before being issued with a circular which made it clear that early or substantial expenditure would not be expected, or even welcomed.[54]

The second aspect of the financial problems of the local authority services was the low priority which, in many cases, local authorities themselves gave to mental health services. Welfare services in particular suffered from a lack of prestige, and many local authorities showed little interest in supplying them. Most local authorities regarded welfare as the least of the functions they performed.[55] Health had, in general, a higher priority, but health services for the mentally disordered ranked, in most cases, far below those for others for whom the L.H.A. was responsible. Many L.H.A.s, perhaps taking their cue from the centre, were not prepared to devote an adequate proportion of their financial resources to the mentally disordered.

The effects of financial stringency and the low priority given to the service were reflected in the figures. Overall, the services

provided by L.H.A.s grew faster than either the hospital or general practitioner services in the years following the creation of the N.H.S. Net spending on them rose from less than four million pounds in 1951-52 to well over seven million a decade later.[56] Overall, after allowance is made for changes in the purchasing power of money, spending rose by 48 per cent, and in some areas such as domestic help and vaccination and immunisation it rose by much more.[57] The mental health service, however, was the only area which did not share in this bonanza. In 1958-59, L.H.A.s spent only 1s 6d in every pound on mental health, compared to the 5s 3d spent on maternity and child welfare, which received the largest slice of the cake.[58] Most revealingly, the L.H.A.s' net spending on mental health was only one thousand pounds higher in 1961-62 than it had been in 1951-52, and, in real terms, spending fell by 25 per cent.[59] Mental health was the only area to experience such a decrease and in the circumstances the Department of Health's admission that the development of the local authority mental health services was among the challenges which had not yet been adequately met was an understatement.[60]

Basically, therefore, local authorities had too many disincentives against the provision of services and too few incentives to provide them. Some, despite the problems they faced, had attempted to provide support, care and training for the mentally disordered, but the history of the local authority mental health service in the years following the introduction of the N.H.S. was to a large extent a catalogue of underachievement. There was a need for measures - including, perhaps, legislation - to promote the thorough ascertainment of the needs which had to be met and to remove as many as possible of the barriers which stood in the way of adequate provision.

There was also a need for the development of the institutional service so that local authorities would not have their resources stretched and diverted in trying to cater for those for whom hospital care was more appropriate. Above all, however, there was a need for a general extension of enthusiasm and initiative at both central and local level. Without it, the expansion of community facilities to the stage at which only those who really needed hospital care would be in institutions seemed unlikely to be attained.

(iii) Voluntary effort in the welfare state

The community services for the mentally disordered would have been in an even less satisfactory state if it had not been for the part played by voluntary organisations. Their role in providing hostels, various kinds of day centres and social services has already been referred to. The final part of this chapter takes a broader view of voluntary organisations in the N.H.S. and, in particular, focuses on their efforts to work with both the statutory sector and with each other.

The inauguration of the N.H.S. posed a new challenge for voluntary organisations. Many of the services which they had previously provided would in future be provided by the statutory sector. The health, welfare and education Acts of the 1940s had given local authorities important new powers in respect of the mentally disordered, some of which had, like the provision of after-care and junior occupation centres, been pioneered in Scotland by the Scottish Association for Mental Hygiene. The new powers given to local authorities were, in one sense, a tribute to voluntary effort, which had recognised the need for and, in some areas, had provided, such

facilities for many years; indeed it was envisaged that, in some cases, they would continue to do so on an agency basis. Nevertheless, it seemed likely that the Association would have to find new ways of channelling its experience and expertise into the new situation. Appropriately, perhaps, the changed circumstances of the 'new' mental health service would be faced by a 'new' Association, since in 1949 the Scottish Association for Mental Hygiene became the Scottish Association for Mental Health.[61]

The continued vigour of the Association, and even its very survival would, to a large extent, depend on its success in convincing the statutory sector and the public that there was still a place for voluntary effort in the welfare state. Some doubted that there was. This attitude was encapsulated in the view of the Carnegie Trust which, in 1954, turned down S.A.M.H.'s appeal for funding on the grounds that the promotion of mental health was now so much a part of the N.H.S. that the need for local voluntary associations, if it existed at all, should arise 'spontaneously', and should not require to be stimulated by a central organisation.[62] Some voluntary workers were themselves unsure of their place in the new N.H.S. mental health service, feeling that the work was 'more or less out of their hands' and that little remained for them to do.[63]

However, S.A.M.H. continued to enjoy the confidence of the Department of Health for Scotland and, in particular, of the General Board, whose Commissioners often played a leading part in the Association's conferences and who were always available for consultation. This moral support, however, was not always backed up by adequate financial support. S.A.M.H. did receive Treasury grants during the 1950s, but even in 1960 the grant was, at £850, not much

more than it had been in the pre-war years.[64] The Association was therefore forced to depend increasingly on the less reliable and non-recurring income derived from appeals and bequests.

It was partly because of financial constraints, and partly because of the introduction of the N.H.S., that, in the late 1940s and 1950s, S.A.M.H.'s practical activities were somewhat limited. It did, through its affiliated L.V.A.s, run occupation centres and clubs and provide informal supervision for defectives living at home, but much of its time and energy was devoted to the education of the public, publicity - regarding both mental health in general and its own activities - and the organisation of courses. It attempted, in a variety of ways, to combat ignorance and develop interest in mental health. It arranged lectures and training courses, such as those held, in conjunction with Glasgow University, on mental deficiency for Medical Officers, and those for instructors at occupation centres. It was acutely aware of the part that the media could play in the formation of positive - and negative - attitudes, and in fund raising, and talks on the Association's work, and appeals, were broadcast on the B.B.C. in the 1950s. It published a 'Newsletter', and was involved in many of the official investigations into the mental health service.[65]

S.A.M.H.'s concentration on the less practical side of mental health work left a gap which another national voluntary organisation partly filled. However, the Scottish Association of Parents of Handicapped Children, formed in 1954, was, as its title suggests, rather more specialised, in both its membership and its aims, than S.A.M.H. S.A.P.H.C. was chiefly interested in childrens' welfare and, in particular, in the provision of junior occupation centres, or day

centres, for children excluded from the education system and for whom the statutory sector had done little. It established branches in many areas,[66] and opened several centres for the low-grade handicapped. But its most innovative project was the conversion of a castle in Cove into a short-stay home for mentally handicapped children. It was the first of its kind in Scotland, perhaps because S.A.P.H.C., as a parents' association, was especially conscious of the need to provide a 'breathing space' for the handicapped and, in particular, for those who cared for them. The extent to which Stewart House was needed was shown by the fact that over five hundred children passed through its doors in the two and a half years following its opening in June 1958.[67]

S.A.P.H.C. was 'astonishingly successful' in a relatively short time, and 'captured the enthusiasm and support of the public', and of several local authorities.[68] Despite its rather different perspective, its activities inevitably overlapped with those of S.A.M.H. From the beginning, S.A.M.H. had made friendly overtures to the new Association but it, fearing - with some justification - that S.A.M.H. was intent on absorbing it, had apparently rebuffed them.[69] Joint meetings of the two bodies had failed to produce useful results and there was some tension between them. S.A.M.H. resented what it saw as S.A.P.H.C.'s unscrupulousness in 'moving in' on S.A.M.H. territory. It was indignant about S.A.P.H.C.'s criticism of its alleged inactivity, and it claimed the moral high ground; while the Parents' Association was interested in providing a service for themselves and for their children, it, S.A.M.H. felt, was 'altogether altruistic'.[70]

At a local level, a more cordial relationship was established in some areas, with representatives of one body attending meetings of

the other: indeed, in Dumfries, an attempt was made to establish a senior occupation centre under joint auspices.[71] In other areas, however, the relationship was either non-existent or openly hostile: in Cambuslang, for example, S.A.P.H.C.'s request for assistance in setting up an S.O.C. in Rutherglen was declined by S.A.M.H. on the grounds that the experience which they had gained should not be passed on to the possible detriment of their own association.[72]

The petty squabbling which went on could only be counter-productive. Each organisation had much to offer the other. S.A.M.H. had its long experience, the contacts and reputation it had built up, and the eminence and expertise of many of its members. S.A.P.H.C. had its youthful vitality, and its members' more personal knowledge of the needs of the mentally handicapped and their families. But instead of co-operation, both Associations seemed, too often, to prefer competition, and made two separate calls upon the energies of those interested in mental health and upon the financial resources of the statutory sector and the charitable public. The existence of two separate voluntary bodies working in the same field caused public confusion, particularly in those areas where both had branches.[73] The feuding that took place cannot have enhanced the public's view of voluntary organisations, nor helped to persuade those who doubted the relevance of voluntary effort of their case. Above all, perhaps, it was not helpful to those whom both organisations had been established to help.

The only possible positive side-effect of the friction between S.A.P.H.C. and S.A.M.H. was that it may have encouraged the older Association to take a fresh look at itself. The increasing stress upon care in the community, however, also contributed to the shift of

emphasis which took place within S.A.M.H. in the late 1950s and early 1960s. One aspect of this re-orientation was the increased interest in the visitation of patients in mental hospitals. The work was not new - S.A.M.H. had previously encouraged its local affiliates to undertake it, either as part of their own work or in association with existing visiting groups - but the increased emphasis on the need to break down the isolation of the mental hospital and the mental patient from the community resulted in an upsurge of activity. In 1957, a voluntary visiting group for patients in Dingleton Hospital was formed. 'F.O.R.A.K.' - The Friends of the Royal and Kingseat Hospitals - was formed in Aberdeen by representatives of various voluntary groups, including the L.V.A. for Mental Health, in 1959, and The Friends of Crichton Royal began their work in the following year. All these groups aimed to maintain or, in some cases, to re-establish, contact between patients and the outside world and, in a variety of ways, attempted to make hospital life less 'institutional'.[74]

In other cases, however, co-operation between the statutory and voluntary sections was less evident. Some hospital superintendents seemed reluctant to co-operate with voluntary organisations.[75] Local authorities, too, adopted widely differing attitudes. Some were appreciative of the contribution that voluntary organisations could make, and even felt that there were many things that the voluntary sector could do better than the statutory sector. Some provided considerable financial backing to local voluntary projects. In other cases, however, co-operation was minimal, and some local authorities felt that when statutory powers were given to a local authority 'it should get on with the job and never mind what voluntary organisations had done, were doing or could do if asked'.[76]

In some areas, then, voluntary organisations came up against the barrier of statutory non-co-operation. It was, perhaps, understandable that the statutory sector would sometimes resent what it saw as interference from do-gooders . But the voluntary section had shown - as in the cases of Stewart House, the Red Cross Centre and Todhill Hostel - that it was still capable of pioneering and innovative work. It was, perhaps, to be expected that as the services which fell to be provided by the statutory sector increased, the role of the voluntary sector would contract, but it was unfortunate that, in a field where such commodities were sometimes in short supply, the enthusiasm and energy of volunteers was not, in some cases, better appreciated and utilised. Nevertheless, contrary to some expectations, the voluntary sector had survived the advent of the welfare state. Far from destroying the voluntary sector, a major new voluntary organisation - S.A.P.H.C. - had been formed and S.A.M.H. was, by 1960, planning to extend its activities. The voluntary sector had proved to be more resilient than many had forecast.

Chapter 11 The Movement Towards Informality

(i) The impetus for reform

(ii) The official response: from Russell to Dunlop

(iii) The Mental Health (Scotland) Act 1960 and its aftermath

(i) The impetus for reform

The most remarkable aspect of the innovations which took place in the 1950s was that they took place at all. They did so within the context of a legal framework which, though added to and modified in the interim, had remained substantially unaltered for a century. The 'new' N.H.S. mental health service worked - or tried to work - within the parameters of a legal code which was increasingly anachronistic. Its archaic nature became more apparent following the creation of the N.H.S., which had been intended to create an integrated mental and physical health service. The mental health service, however, continued to be marked out from the rest of the service by a specialist central authority, by public attitudes and by the isolation of psychiatry from the medical mainstream. Above all, it was differentiated by the continuing operation of Lunacy and Mental Deficiency Laws based on judicial process, compulsion and detention. The extent to which a modern mental health service could develop was circumscribed by the barrier of laws which bore little relevance to the realities of the second half of the twentieth century.

Nevertheless, the need for reform was not all that obvious. In fact, the mental health service appeared to be in a healthy state in the 1950s; the N.H.S. was in operation, therapeutic innovations were taking place and the number of voluntary patients was steadily increasing. These factors, however, actually contributed to the pressure for reform. The introduction of the N.H.S., which brought the physical and mental health services into closer contact, highlighted the differences between them. The explosion of therapeutic experimentation, though demonstrating that development was possible within the existing structures, also served to focus

attention upon the contrast between the more adventurous hospital climate and the stagnation of the legal basis of the service. The increasing number of voluntary patients had a similar effect; the hospital was becoming more dynamic, while the legal structures ossified.

The growth in the number of patients entering hospital of their own accord also drew attention to those to whom the option was still denied. Criticism of existing policy had been brought to a head before by the realisation of the way in which it appeared to operate unfairly upon particular groups; agitation for the extension of voluntary treatment had been stimulated by the need to certify civilians, but not service patients, during World War One, and by the requirement to certify paupers, but not necessarily private patients, during the 1920s. Now attention was focused upon the 'certifiable but willing' category and upon 'non-volitional patients'. The inter-war debate on the legality of admitting as voluntaries patients who, though anxious to receive treatment, were certifiable appeared by the late 1940s to have been settled by the conclusion that it was illegal to do so:[1] and the 'willing but certifiable' could not be admitted to hospital without certification. Certification was also a pre-requisite to treatment for those who were unable to make the formal application for treatment that voluntary admission required. Thus, non-volitional patients - those in the acute stage of recoverable mental illness, and senile patients - who could not, or would not, express a positive desire for treatment were certified.

The injustice of certifying these patients became increasingly apparent in the years following the Second World War, when the growing proportion of elderly people in the community[2] highlighted the

continued need to certify harmless geriatrics and when the increasing use of voluntary admission concentrated attention upon the still limited availability of the provision. Inroads had been made into the compulsory basis of the service, but the legal barriers against the voluntary admission of non-volitional and certifiable but willing patients meant that a large proportion of patients still had to be certified. The voluntary mode of admission was not infinitely elastic, and without some reform of the legal basis of the service many patients would continue to be subject to certification, judicial process and compulsory detention. Few doubted that compulsory powers must be retained for use in certain cases, but there was a strong desire to make the number of such cases as small as possible. The denial of voluntary treatment to those whose derangement rendered them temporarily unable to consent to treatment, to those whose condition meant that they could not recognise the need for treatment,[3] to those who were prepared to receive treatment but who were certifiable and particularly to those whose state of mind was the result of advanced age was widely regarded as 'a ridiculous ... anachronism contrary to all medical and humanitarian interests'.[4]

The pressure for less formality applied to extra-institutional provisions too. Community care which was available only after the patient had undergone certification and judicial process was hardly worthy of the name. There were community services which were available to all, or which were specifically limited to those who were not certified, but in some instances extra-institutional care was as hedged with legalism as hospital admission; the placement of patients under guardianship, in particular, involved formal, and in some cases judicial, procedures.[5] Attention was therefore also focused on the

need to provide community care for those who did not require certification or removal from their homes, but who would benefit from some less formal type of care. In the years following World War Two there was a demand for both the extension of community amenities and for them to be provided on the basis of need rather than legal status.

Another important stimulus to reform was the maturation - or, more accurately perhaps, a belief in the maturation - of public opinion which, it was felt, was ready to accept a radical change in the mental health service. It was recognised that mental disorder was still the object of fear, ignorance and prejudice, but from the late 1940s, and particularly in the 1950s, the increasingly enlightened attitude of the general public became part of the conventional wisdom of the period. Various explanations, including the introduction of the N.H.S. and the abolition of the Poor Law, were advanced to account for it, but it was most commonly ascribed to the new therapeutic methods which have already been described and which, by seeming to cure mental illness in many cases, encouraged the public to see mental hospitals as places of healing rather than incarceration.[6] The more rapid turnover of patients, too, meant that more people came into contact with ex-mental patients, and thus had a more realistic view of what actually happened in institutions. The concept of the community's more sympathetic outlook, then, was widely accepted, and was endorsed by, among others, the Russell Committee, the Royal Commission on Mental Illness and Mental Deficiency, the Department of Health for Scotland, the General Board and the Scottish Association for Mental Health. In Parliament, too, 'the public was praised for its tolerance, understanding and readiness to have the mentally ill in its midst'.[7]

However, the extent to which such a change had actually occurred is open to question. There was little evidence to validate these optimistic claims, and the evidence from the grassroots of the service - and particularly from local voluntary bodies - suggested that, at best, the public attitude had shifted from outright hostility to mere apathy.[8] It is, in any case, not easy to identify any absolutely reliable barometer of public opinion. The number of patients entering hospital voluntarily was sometimes cited; it, however, was the continuation of a trend which had begun many years earlier. The increasing use of psychiatric out-patient departments and the various types of clinics was encouraging, but, given the more widespread availability of such facilities, was hardly conclusive. The increased publicity given to mental health matters in the media perhaps did seem to indicate some movement; while it was not uniformly admirable, mental health did get a reasonably 'good press' in the 1950s.[9] The strongest 'evidence' of progress, though, was the degree of unanimity, among some of those most closely involved with the service, that public opinion, if not transformed, had at least made 'a gradual but steady' improvement'.[10]

Rumblings of public apprehension were heard as reform became inevitable, but there was no serious upsurge of public opinion against it. Many were, undoubtedly, unaware of the steps that were being taken, while others may simply not have cared. Even indifference was preferable to antipathy, however; while the reformed mental health service would ideally require the whole-hearted co-operation of the community, it could not hope to survive blatant dissension. In the final analysis, the extent to which public opinion had changed is very difficult to measure, and may even not have been as important as the

general perception that it had. Without that perception, it is unlikely that the legislative changes of 1960 could have taken place.

While much of the pressure for the reform of the service was concerned with the reduction of unnecessary 'red tape' and with increasing patients' liberty, there was also pressure to reform the service so as to include within its scope a group who, in many cases, had not previously come under the Lunacy or Mental Deficiency Acts - psychopaths. Psychopathy was seen as a personality disorder rather than a mental illness, and was variously attributed to organic factors - brain defects - or to environmental influences such as childhood experiences. Some believed that there were two groups of psychopaths: the predominantly 'inadequate', who were sometimes below normal intelligence, and the predominantly 'aggressive', who did not exhibit any intellectual impairment. Others considered that only those in the second group were truly psychopathic. There was more agreement on the traits of psychopathy. Psychopaths were emotionally immature or unstable, and lacked control and reasoning power. They lacked any appreciation of the effects of their actions upon others and seemed 'impervious to pity or remorse'.[11] This amorality was associated with a range of anti-social behaviour which, in the inadequate psychopath, might be a general inability to live an independent and socially acceptable life and, in the case of the aggressive group, could take the form of aimless, random violence. Punishment or treatment appeared to have little effect on their behaviour.

The psychopathic group had attracted interest before World War Two - in 1937, Professor Henderson of the Edinburgh Royal Hospital had remarked on those whose 'moral blindness' made them dangerous to themselves or others[12] - but it was most evident in the 1940s and 1950s.

The reason for this intensification is not clear - there was no conclusive evidence that the number of psychopaths was increasing. Various explanations have been advanced to account for it, though none is wholly convincing. Perhaps socially unacceptable behaviour became more important at a time when the nation was mobilising all its resources in the fight for national survival. It may be that, as the number of voluntaries increased and as the mental hospital became more dynamic, those who were resistant to treatment became more obvious. Or it may be that it was simply an example of the process of the 'psychiatricisation' of deviance, which preferred to cast people as 'mad' rather than 'bad'. For whatever reason, pressure to make the service more inclusive and comprehensive by extending its provisions to the psychopathic group grew. Professor Henderson, recognised as an (if not the) authority on the condition, was at its forefront in Scotland.

(ii) The official response: from Russell to Dunlop

The question of informal admission to mental hospitals, which was to become a central part of the subsequent debate, was discussed by the Russell Committee in its 1946 report. A minority of witnesses had urged that the admission of the mentally disordered into asylums should be as informal as that of those with a physical illness into a general hospital. But the Committee had rejected this evidence, believing that special legal and medical safeguards were necessary, though it did stress that compulsion should be used as little as possible. It proposed instead, in its major recommendation, that the problem of the non-volitional patient could be solved by adopting, with minor modifications, the provisions of the 1930 English Mental

Treatment Act, which would permit non-volitional patients to be detained for a short period on the basis of two medical recommendations and without a judicial order. This new intermediate category of temporary patient would thus be added to the existing ones of voluntary and compulsory patient.[13]

The Committee made numerous other recommendations. It advocated changes in terminology; the terms 'lunatic', 'insane person' and 'person of unsound mind' should be dropped, and superseded by the generic term 'mental patient', and terms like 'lunatic asylum' should also, it believed, be replaced by terms 'more pleasing to the public and fairer to the patient'.[14] It also felt that the remaining links between the mental health service and the Poor Law should be broken and that lunatic wards of poorhouses, which perpetuated this association and which provided generally low standards of care and treatment, should be discontinued.[15] It recommended an extension of facilities - including observation wards and psychiatric clinics - for extra-asylum treatment, and emphasised the need for better after-care.[16] Finally, it stressed the need for special mental health committees of local authorities,[17] and suggested the clarification of some of the General Board's powers.[18]

The Committee also considered changes in the legal basis of the mental deficiency service. The Society of Public Assistance Officials suggested that some mental defectives - such as moral imbeciles over twenty-one - should be admitted to institutions on their own application, and that, in other cases, parental wishes alone should be sufficient authority for the defective to be dealt with. But the Committee rejected any relaxation of the necessity for medical and legal authority, on the grounds that there were not satisfactory or

sufficient reasons to make such changes.[19] It did, however, recommend other reforms. It stressed the need for an expansion of community facilities for mental defectives, and emphasised the need for informal supervision for defectives outside institutions.[20] Moreover, and as in its recommendations in respect of the mentally ill, the Committee was convinced that terminological changes were needed. On the grounds that the current terms caused a good deal of public objection, it recommended that three of the grades introduced in 1913 - the feeble-minded, imbeciles and idiots - should be replaced by three categories called simply A, B and C. The fourth category of moral imbecile, which had proven very difficult to apply in practice, should, it recommended, be abolished.[21]

In general the Russell Report acknowledged that the Scottish Lunacy Laws had not kept pace with 'changes in public sentiment and the developments in mental science',[22] and it endorsed some of the principles which would later be echoed by other investigations. It believed that there should be a less rigid separation between mental illness and mental deficiency, which should be brought under one code, it felt that an expansion of community care was necessary and it recognised that some liberalísation of the compulsory basis of the service was needed. It also raised, though it did not always answer, questions which would be at the forefront of the subsequent debate; questions relating to the terminology and classification of mental disorder, the position of the General Board, and the arrangements necessary to ensure that local authorities carried out their functions in respect of the mentally disordered. But much of the Report was concerned with procedural minutiae. These details were not unimportant and the Committee's remit was confined to the Lunacy and

Mental Deficiency Laws. Nevertheless, in view of the sweeping changes that the introduction of the N.H.S. was soon to bring, the fact that its most important proposal was for the extension to Scotland of a sixteen-year-old English Act was somewhat disappointing.

The report's caution was criticised from within the Committee by Professor Henderson. He regarded its proposal to extend the Mental Treatment Act to Scotland as 'an unfortunate suggestion', and went further than the rest of the Committee in commenting on the prospective N.H.S., stressing that mental health must really be an integral part of the new service. Above all he objected to the general tentativeness of the report's tenor, and advocated a 'drastic' alteration in admission procedure so as to allow all non-voluntary admissions to be treated, for up to six months, without a judicial order. This, he felt, would really make early treatment possible by eliminating, at least in the early stages of illness, the 'bugbear' of certification.[23]

There was also some criticism from without. Cyril Greenland, psychiatric social worker at the Crichton Royal Institution, felt that the report lacked focus, enterprise and a sound grasp of the purpose of a mental health service.[24] Dr. Chambers, Physician-Superintendent of the Murray Royal Asylum, believed that its recommendations were generally 'doubtful improvements on existing law and practice'.[25] The report, then, was something of an anti-climax. Perhaps because of the hiatus between the establishment of the Committee in 1938 and the publication of its report in 1946, it appeared more appropriate to the pre-war situation than to the post-war world.

It was clear, therefore, that in the years immediately following the war some informed people, like the majority of the

Russell Committee, believed that improvements in the mental health service could be obtained by modifying the existing structures: they were primarily concerned with 'administrative tidiness and legal efficiency'.[26] Others, however, were convinced that some more radical alteration in the legal and administrative basis of the service was necessary, and that the continuation, even in a modified form, of the current system could not achieve the desired results. There was a feeling of impatience, which was encapsulated in Professor Henderson's remark that the mental health service had made no more impression upon mental disorder than that obtained by scratching a rock with a pin,[27] and in his assertion that the time had come to break down much of the existing judicial procedures which were a relic of the 'bad old days'.[28] There was above all a feeling of being at a crossroads, and that with the impending introduction of the new N.H.S. a historic opportunity was being offered to weld.the mental and general health services 'into one homogeneous scheme' which, if missed, would reinforce the 'ancient gulf' between them.[29] The Russell Report did not capture this new mood.

However, even those who did not support the Russell recommendations felt that legislation to implement them was imminent. The Committee had been reactivated in 1943 because of the general belief that the mental health service in its existing form could not be successfully integrated into the N.H.S., and as late as spring 1946 the assumption was still being made that some sort of overhaul of the mental health service would soon be carried out.[30] Indeed the question of including the provisions relating to temporary patients in the N.H.S. Bill was discussed. The Secretary of State, however, felt it would not be appropriate to do so in what was essentially a

'machinery' Bill. It was, in any case, envisaged that a Bill dealing specifically with lunacy and mental deficiency would be required; and it was even envisaged that this mental health Bill would be law before the N.H.S. came into operation.[31]

In the event, however, this Bill never materialised. Some of the Russell recommendations were incorporated into the N.H.S. (Scotland) Act 1947,[32] but its major recommendation on temporary patients was not introduced then or subsequently. Perhaps it was too controversial. It is more likely, however, that it was simply 'lost' in the massive reorganisation of the introduction of the N.H.S.[33] For whatever reason, an opportunity had been missed. The need for reform of the service had been recognised in the discussions leading up to the creation of the N.H.S., but seemed to be temporarily forgotten. The legal structure of the mental health service which had in the mid-1940s been considered so outmoded as to constitute a barrier to its inclusion in the N.H.S. had to stagger on for another fifteen years. The 1960 Act can, in this sense, be seen as an attempt to complete the unfinished business of 1947.

The Russell proposals were resurrected in the mid-1950s. Because the Scottish Lunacy and Mental Deficiency Laws had been reviewed fairly recently, they were not included in the remit of the Royal Commission on mental health law which was appointed in 1954.[34] Instead, the Department of Health in 1955 produced a White Paper on Scottish mental health law which considered the Russell recommendations in the light of the changes which followed the introduction of the N.H.S. and the abolition of the Poor Law. It recognised the unacceptability of the necessity to certify certifiable but willing patients and conceded that - as many asylum superintendents in the

inter-war period, and many witnesses to the Russell Committee had argued - such patients were often capable of making the decision to enter hospital voluntarily. It therefore proposed the repeal of the ban on the voluntary admission of certifiable patients, and the general simplification of the procedure for voluntary admission.[35]

The White Paper also recognised the problem of the non-volitional patient. It, like the Russell Committee, proposed the introduction of a new intermediate category, the 'recommended patient'. Where the patient was incapable of giving consent to voluntary treatment, or where the patient was unwilling to do so but his relatives were willing, he or she should be able to be admitted, without a judicial order, on the authority of two medical recommendations; the procedure would, the White Paper noted, be particularly appropriate for senile patients. Procedure by way of judicial order would be retained for use when the recommended category was inappropriate, but changes to it were also proposed. The certifying doctors should no longer have to certify the patient as a 'lunatic', an 'insane person', an 'idiot' or a 'person of unsound mind', but merely as a person who required to be detained for the purposes of care and treatment.[36]

In its proposals relating to mental defectives, the White Paper recommended that the existing requirement for the defect to be present from birth or an early age should be abolished. This stipulation of the 1913 Act, which had been a barrier to proper provision for those who became defective as a consequence of disease or injury later in life, had been much criticised in the past; now, 'in the light of experience', it was proposed that the provisions of the Acts be extended to all cases where mental deficiency arose before the age of

twenty-one. Further, and as in the case of those certifiable under the Lunacy Acts, the White Paper advocated the abandonment of the current four categories of the mentally defective and recommended that, in future, the certifying doctor should be required to state only that the person was mentally defective.[37] This abolition of the current designations would involve a further alteration of the statutes but, surprisingly, the White Paper chose to propose a tightening of the compulsory basis of the service. 'Idiots' and 'imbeciles' had, in the past, been able to be dealt with, at any age, without a judicial order, but the White Paper proposed that an order should be required to deal with any defective over twenty-one who was not already in an institution or under guardianship.[38] The recommendation may have been prompted by a desire to safeguard the interests of the more severely handicapped adult, but it does, nevertheless, seem strange that, in a climate of opinion which demanded less formality in the treatment of the mentally disordered, the White Paper suggested this extension of judicial intervention. This preoccupation with legalism was reflected in many of its other proposals in respect of mental defectives, but it did also urge that local authorities be required to provide informal supervision for uncertified defectives living in the community.[39]

The White Paper declared that its recommendations were designed to bring mental health law and practice into line with 'current and more enlightened ideas of psychological medicine'.[40] In reality, though, there was little that was 'modern' about them. The proposed introduction of the 'recommended' category merely echoed the Russell Report in its advocacy of the extension to Scotland of this provision of the English Mental Treatment Act which was, by 1955, a quarter of a

century old. Its recommendation on the repeal of the 'birth or an early age' clause would also only serve to extend to Scotland a provision which had applied in England since 1927; and it actually wanted to limit further the circumstances under which a mental defective could be dealt with without a judicial order. It was generally 'an austere document'.[41] It did not reflect the more optimistic outlook of post-war psychiatry or the changes which were taking place within the hospital service, and was more an attempt to shore up the creaking framework of the current service than a fresh approach. Its hesitancy appeared almost embarrassingly anachronistic when compared to the proposals of the English Royal Commission on Mental Illness and Mental Deficiency. Its 1957 report was to have a major impact on the Scottish debate.

Its single most important recommendation was that concerning informal treatment; whenever possible, suitable care should be provided for mentally disordered patients with no more restriction of liberty or formality than was applied to any other patient. Patients admitted in this way would no longer have to sign an application for admission, nor give formal notice of their intention to leave. Even patients who were unable to express a positive desire to enter hospital should be able to receive treatment on an informal basis; the assumption should be, as it was in the case of the physically ill, that they were willing, or at least content, to receive treatment unless they or their relatives positively objected. The report, in fact, urged the abandonment of the principle that compulsory powers must be used unless patients provided positive evidence of their wish to receive care, and its replacement by the offer of care, without formality or loss of liberty, to all who needed it and were not

unwilling to receive it. By this means, informal admission would be available both for those who had been able to receive treatment as voluntary patients, and for many of those who were currently subject to compulsory detention. Compulsion would become a last resort.[42]

The Commission was convinced that there would still be circumstances in which society must be able to compel patients to receive treatment. But, it stressed, detention should not be used for detention's sake; no form of mental disorder was, by itself, sufficient grounds for depriving a person of his or her liberty. Compulsion must be used only when it was necessary to provide the training or treatment which the patient needed and which could not be provided otherwise, or when it was needed to protect others from the patient's anti-social behaviour. The Commission recommended new procedures and safeguards for these cases where compulsion was deemed necessary. The most radical changes it proposed were the abolition of certification and the removal of the justices from the admission process. Applications for detention would be supported by medical recommendations, rather than by certificates and an order; these recommendations - two, normally, but one in an emergency - should include a diagnosis of the patient's condition, and the grounds upon which the recommendation was made, including an explanation of why it was not possible for the patient to enter hospital or guardianship without compulsion.[43]

This new procedure, the Commission believed, would provide more safeguards for the patient than did the current recourse to a magistrate. The necessity, in most cases, for two medical opinions would be backed up by new regulations to ensure the competency of the recommending doctors, by the extension of powers of discharge, and by

the creation of independent bodies, Mental Health Review Tribunals, to which appeals against detention could be made.[44] Its proposals, the Commission felt, had other advantages too. Certification, with its connotations of life-long instability, would be replaced by recommendation, a means 'of providing a patient with the form of care appropriate to his needs at the time'.[45] The abolition of judicial detention would break the link between mental disorder and criminality and, the Commission felt, help to lessen the stigma attached to detention. It would also serve to emphasise the medical nature of mental disorder as an illness which required treatment. The proposed abolition of judicial detention was not, perhaps, so radical in England and Wales - where treatment on recommendations, without certification or a justice's order, had been available since 1930 - as it would be in Scotland. Nevertheless, the removal of any legal component in compulsory admission would still be a major departure from past practice.

The Commission's view of the future shape of the mental health service was reflected in a number of other important recommendations. The relaxation of the rigid separation of the mentally ill and defective should, it urged, be reflected administratively by the abolition of the formal designation of hospitals. The choice of hospital should, in future, be determined by the type of treatment which the patient required, and its availability, and mentally disordered patients should be accommodated in the type of institution - whether mental hospital, mental deficiency hospital or general hospital - best suited to their needs.[46] The limited use of compulsory powers which the report envisaged in the future held implications for the future of the English Board of Control. Its work

would be substantially reduced if the proposals were implemented, and if the Mental Health Review Tribunals were established. It would, the Commission believed, have outlived its usefulness, and should be abolished.[47]

The Commission further recommended that there should be a general re-orientation of the mental health service, away from institutional care in its current form and towards community care, and more emphasis on the forms of treatment, training and social service which could be given without admitting the patient to hospital at all, or which could make it possible to discharge patients from hospital sooner. The aim of in-patient treatment, it stressed, must be to make the patient fit to live in the general community, and patients who were able to do so should not live for long periods in large or remote institutions, cut off from the normal world and from mixing with other people. The report recommended a considerable expansion of both the residential and non-residential community health and welfare services - including the provision of hostels and residential homes, training centres, and social work services - in close co-operation, where appropriate, with the hospital service and voluntary organisations. Significantly, it was convinced that if the necessary facilities were to be provided, the permissive powers of local authorities would have to be converted into positive duties.[48]

The report also recommended changes in the classification of the mentally disordered; public opinion had out-grown the old, and frequently offensive, terminology, and reform was also necessary to break down the rigid separation between the mentally ill and defective. It thus proposed that the generic term 'mental disorder' should be used to denote all forms of mental disability. Included

within this broad category would be 'mentally ill patients', 'severely sub-normal patients' and, more controversially, 'psychopaths'. This last group would include not only patients currently classified as 'feeble-minded' and as 'moral defectives', but some who had not been included in any category; those whose intelligence was not seriously impaired - or was even above normal - but who manifested abnormalities of personality which made special forms of treatment necessary.[49]

The Commission recognised that psychopathy was a very difficult area. In particular, if psychopathic patients were to be subject to the same compulsory powers as other groups of the mentally disordered, it would mean that people who had not broken the law could be detained in hospital because of behaviour which, in other individuals, might not be held to indicate psychopathy and which would not render them liable to detention; it would, in fact, be tantamount to the creation of a special quasi-judicial code for psychopaths alone. Because of this, some witnesses believed that compulsory powers should not apply to psychopaths who had not broken the law. The Commission, however, finally recommended that compulsion should be limited to young psychopaths, to those who required short periods of observation and to those who had broken the law.

Even the recognition of the psychopathic group was controversial. It carried echoes of the old term 'moral imbecile', but the crucial difference was that whereas moral imbeciles had to exhibit mental defect in addition to their other traits before being so categorised, the psychopath would not. The Commission stressed that pscyhopathic behaviour was motivated by an underlying condition of abnormality, but it was still skating on very thin ice, for, as it recognised, if one concentrates on the patient's behaviour rather than

on the mental condition which lies behind it, one comes very close to making certain forms of behaviour in themselves grounds for segregation from society. Observed behaviour had previously been a major determinant of a diagnosis of mental illness or mental deficiency. But the Commission proposed the creation of a group in which it was frequently the only evidence of the assumed disorder, and the designation of a condition which was not associated with any specific mental illness or intellectual impairment, and which different psychiatrists and sociologists regarded in different ways. It is not surprising that the Commission did not even attempt to provide a precise definition of psychopathic personality.[50]

The Royal Commission, then, proposed sweeping changes in the terminology, classification, administrative structures, orientation and procedures of the mental health service. It advocated the reform of almost every aspect of the service, and envisaged a shift in its very ethos. Its recommendations regarding the drastic curtailment of compulsion, the abolition of certification in its current form, and the introduction of informal admission and discharge did not merely aim 'to alter in a profound way a long-standing legal practice',[51] but to change the whole essence of the service. It visualised a mental health service allied more closely than ever before to the rest of the health service, freed from outworn and stigmatising judicial processes, and interfering as little as possible with the liberty of the patient. Its breadth of vision was in striking contrast to the Russell Report and the 1955 White Paper.

The Commission generally received a very favourable reception. Even its most contentious proposal - the recognition of the psychopathic group - appeared to attract less controversy than might have

been expected. Some warning voices were raised against it, pointing out the danger of identifying non-conformity with a pathological condition,[52] but many welcomed the proposed recognition of the group as ill rather than merely wicked, seeing it as evidence of a more humane and enlightened attitude. The House of Commons discussed the report in July 1957, when the majority of those present accepted it as a sound basis for new legislation. In Scotland, the most important reaction to the report came in September 1957, when a committee of the Scottish Health Services Council was appointed to consider the application to Scotland of the Royal Commission's major recommendations, in the light of the 1955 White Paper, and was asked to report by February 1958. Because time was so short, the Dunlop Committee considered the Royal Commission's recommendations only in the broadest way, took no evidence and held only six meetings.[53] Despite these exigencies, however, it still produced a very significant report.

An important departure from the Royal Commission's recommendations came at the start of the Dunlop Report. It recognised that patients exhibiting severe behavioural disturbances of an anti-social or violent nature presented special problems for which provision had to be made, but it did not believe that a new psychopathic category should be defined separately from mental illness or deficiency. The term 'psychopathy', the Committee felt, had already come to have so many meanings that it had almost no medical significance, and its statutory recognition would only add to the existing confusion. Nor would the problem of stigma be solved by substituting 'psychopathic' for 'mentally defective', since both terms connoted a relatively unalterable state. The creation of a new category of mental disorder purely for the purpose of compulsion would also, the Committee felt,

be contrary to the aim of reducing the use of compulsion. Above all, it did not agree that compulsory procedures should be used for anyone who was not medically recognised as mentally ill or defective. The Committee therefore took a significantly narrower view of the role of psychiatric intervention in socially unacceptable behaviour. Most psychopaths who could benefit from psychiatric care or treatment could, the Committee asserted, receive it either as mental patients or mental defectives, either in existing facilities or new special units.[54]

In its other recommendations, too, the Committee was not afraid to dissent from the Royal Commission's stance. Its attitude underwent something of a change during its deliberations. While it approached its task with a belief that the best traditional features of Scottish law and practice should be preserved, it had been equally convinced that Scottish law and practice should be as similar as possible to that of England. Experience, however, proved these objectives to be in some instances incompatible. The Committee began to doubt the received wisdom of England's superiority in mental health law and gradually formed the view that 'certain features of the law in Scotland were - for Scotland - more satisfactory than their English equivalents'.[55] It determined that provisions which had proven their worth, and which enjoyed public confidence, would not be sacrificed on the altar of Anglo-Scottish uniformity.

The first of these provisions was the more intimate connection in Scotland between the Board of Control and patients. This relationship, which was a consequence both of the legal structures and the smaller size of the service, was, the Committee felt, 'something of real value which should not be abandoned except for very strong

reasons'.[56] It echoed the sentiments expressed twenty-one years before by the Gilmour Committee; patients showed special appreciation of the interest taken in them by the Board's Visiting Commissioners, and patients, staff and the public had confidence in the Board's safeguarding of patients' interests. Some measure of reform was, nonetheless, necessary, and in accordance with its view that voluntary patients should be treated as far as possible like patients with physical ailments, the Committee recommended that the Board's functions should, in future, be confined mainly to compulsory patients. It also proposed that the dual role of the Board's Medical Commissioners should be discontinued, and their duties confined to Board work.[57] Subject to these changes, however, the report recommended the retention of the General Board; once again, it differed from the Royal Commission.

The Committee accepted some of the Royal Commission's recommendations regarding compulsory admission to hospitals or to guardianship.. It stressed that compulsion should be used only when it was unavoidable, and underlined the need to ensure that the doctors involved were equipped to undertake their role. One of them should be specially experienced in the diagnosis and treatment of mental disorders - and should preferably be a psychiatrist - while the other should be the prospective patient's family doctor. Both should be familiar with the person to be examined.[58] But the Committee disagreed with one of the Royal Commission's major recommendations; the judicial authority, it felt, should continue to be a participant in the process for compulsory admission. The current procedure, it felt, had worked smoothly; surprisingly, in view of the adverse comment that judicial involvement had attracted, the Committee did not

feel that it caused relatives any particular difficulty, and asserted that it had not given rise to the criticism levelled against the corresponding English procedures. Above all, however, the Committee's recommendation was prompted by its conviction that medical authority alone would not be a satisfactory basis for detention. Except in exceptional cases, it felt, it was wrong for a person to be deprived of his liberty for any length of time solely on the doctors' recommendations. The additional safeguard of judicial authority, the Committee believed, was necessary. Indeed, it noted, there had been occasions when the Sheriff had, properly, declined to grant a warrant.[59] The Dunlop Report appeared to regard judicial authority as an essential check to untrammelled medical hegemony, which was strikingly different to the approach of the Royal Commission.

In its first report, the Dunlop Committee declared itself to be in general agreement with the Royal Commission's recommendations on community care,[60] but it had insufficient time to consider the matter in any detail. When it became clear that more time was available than had first been thought, the S.H.S.C. asked the Committee to resume its deliberations, and its second report, on community services for the mentally disordered, was published in 1959. It endorsed the Royal Commission's principle of a shift of emphasis from institutional to community care, and stressed that everything possible should be done to enable the mentally disordered to enter as fully as possible into the life of the community. This, it recognised, would require the extension, and in some instances the creation, of community services.[61]

The Committee stated that its recommendations were 'substantially in line' with those of the Royal Commission.[62] In fact, the

Dunlop Report differed from the Commission's proposals on ccmmunity services in one very important respect; while the English report had recommended that community care should be a positive duty on local authorities, the Scottish report concluded that, except in respect of existing duties, the future functions of local authorities should be powers rather than duties, though it should continue to be open to the Secretary of State to convert them into duties.

Why, then, did the Committee recommend this 'middle way', albeit, it admitted, with some hesitation? It was, firstly, concerned to maintain continuity with the existing provisions of Part III of the National Health Service (Scotland) Act 1947, which were in the form of permissive powers with a reserve power of direction in the Secretary of State's hands. It would, the Committee believed, put mental health in a very special position if the functions under it were made mandatory. Secondly, the Committee's proposals were, as it pointed out, in line with those of the new Mental Health Bill for England and Wales. Thirdly, the discretionary element was felt to be necessary in view of 'geographical circumstances' - or regional differences - since it would be impossible for remote rural areas to provide all the elements of a complete community service.[63]

The Committee's justifications for its stance, however, did not appear wholly convincing. In its first report, it had repeatedly shown that it was quite prepared to countenance differences between English and Scottish law and practice if it believed they were necessary, yet now it cited the provisions of the English Bill to re-inforce its argument. Its reference to the N.H.S. Act also seems somewhat spurious; the fact that functions had previously been discretionary seemed a poor reason for keeping them that way. Indeed,

if, as was generally acknowledged, many local authorities had failed to use their existing powers to provide for the mentally disordered, it seemed unrealistic to expect them to provide an expanded range of services if they were not obliged to do so. Indeed, the Committee itself acknowledged that there had been a lack of enthusiasm and initiative on the part of some local authorities, and that the D.H.S. had not given a sufficiently strong lead, without giving much indication of how these difficulties could be resolved.[64] It seems likely, then, that the imposition on local authorities of a statutory duty to provide a comprehensive community care service was regarded as too expensive for, as the Committee realised, even the modest improvements it had recommended would, in many cases, take some time to implement.[65]

The Committee in fact seemed aware that its proposed retention of the discretionary principle might attract adverse criticism. Its report was almost apologetic in tone - it acknowledged that the changes that it recommended would not, in themselves, alter the current situation greatly - and was somewhat defensive, emphasising that it had reached its conclusions only after 'prolonged and careful consideration'.[66] When the Committee reported to the S.H.S.C. there was indeed an intense debate, and some Council members were convinced that if local authorities did not have a statutory duty to provide community services, what was necessary would not be done. The S.H.S.C. however did finally agree to inform the Secretary of State that it concurred with the Dunlop recommendations, on the understanding that he would keep the situation continuously under review, and that when new mental health legislation did come in he would invite local authorities to submit schemes showing how they proposed

to discharge their functions. It recognised that, without the spur of obligation, close supervision of the local authorities' performance would be required.[67]

There were therefore very real differences between the English Royal Commission and the Scottish Dunlop Committee on the provision for psychopaths, the place of legal authority in the mental health service, the need for a specialist central authority and the form that local authority functions should take. But there were also broad areas of agreement, particularly on the need to reduce the role of compulsion. A breach in the compulsory basis of the service came in fact without any legislation when in 1958 the D.H.S. intimated to hospital authorities that, in appropriate cases, they should admit mental defectives informally, with no powers to detain;[68] and the authorities were also asked to review the status of existing mentally defective in-patients with a view to reclassifying them to informal status. The results were not startling, but in the months which followed a significant proportion of mental deficiency admissions - about a quarter of the total - were admitted informally, and a smaller number of those already resident were transformed to informal status.[69]* The change was, however, a significant indication of developments to come.

(iii) The Mental Health (Scotland) Act (1960) and its aftermath

More radical reforms required new legislation. The White Paper in 1955 had given a broad commitment in favour of this, and in the autumn of 1959 the Queen's Speech announced that legislation would be introduced in the 1959-60 session.[70] In 1960 - a year after the English Mental Health Act was passed and, appropriately, 'World Mental

* 69 Table 11:3 shows the number of informal mental deficiency admissions

Health Year'[71] - the Mental Health (Scotland) Act was passed.

The most important change in Scottish mental health law for over a century was authorised by section 23(3) of the Act. It was remarkably low-key for such an important provision. It did not mention informal admission as such, but provided that 'nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted to any hospital or nursing home ... without any application, recommendation or order rendering him liable to be detained'. In its restrained way, the clause had swept away the need for any lay, medical or legal formality for the majority of patients. Those who needed hospital treatment and who were not unwilling to receive it would, in future, be able to receive it with no formality, and would have the same rights, so far as treatment and the right to discharge themselves, as any other patient. The principle of informality also applied to community care, and thus to patients under guardianship.

It would be difficult to exaggerate the significance of informality. The 1857 Lunacy Act, and all subsequent ones, had been based on the premise that the vast majority of patients would be unwilling to be hospitalised, and would have to be certified. Certification - with its resultant loss of liberty, its stigma and its implications of long-term (if not life-long) incarceration - had, in turn, such a drastic effect on the patient that a forest of legal procedures was introduced to prevent it being applied to those who were sane. Almost every aspect of the service had changed in the interim, in many areas almost beyond recognition. Virtually the sole exception was the legal basis of the service, with its emphasis on compulsion and detention. With relatively minor modifications, it had stood like a rock washed,

Table 11:1 Admissions to Mental Hospitals, 1960-63*

A. Number of Patients

Year	Voluntary	Informal	Certified	Total
1960	10642	-	2298	12760#
1961	84	11733	1768	13585#
1962	-	13118	1585§	14703
1963	-	14163	1694§	15857

Excluding admissions to the State Mental Hospital

§ Including transfers

B. Percentages (approximate)

Year	Voluntary/Informal	Certified	Total
1960	82	18	100
1961	87	13	100
1962	89	11	100
1963	89	11	100

Source: Annual Reports of the General Board of Control for Scotland and of the Scottish Home and Health Department

* While the figures for 1960 and 1961 definitely exclude admissions to the State Mental Hospital, it is not clear whether the figures for 1962 and 1963 exclude them.

and increasingly battered, by waves of organisational, administrative, financial, therapeutical, theoretical and medical change. It had sometimes appeared to be on the point of crumbling, but it was not until 1960 that a major breach in it was made. The principle of compulsion and detention was not swept away, and it would continue to be applied to a significant minority of patients. But for the majority judicial certification and compulsory detention would literally become a thing of the past. The provision was, in one sense, a recognition of changes that had already taken place, for the majority of patients were, by 1960, already entering hospital without certification. In another sense, though, it was truly revolutionary; there was a vital distinction between voluntary admission, which still involved a certain amount of formality and which required the patient to make a positive application for admission, and informal admission. The introduction of informal admission was, most accurately, the revolutionary expression of an evolutionary process in medical attitudes and understanding.[72]

The introduction of informal status was the first fruit of the 1960 Act. The first commencement order under the Act was made before the end of 1960 and from the beginning of 1961 patients were able to enter hospitals informally. Wide use was immediately made of the new provision, and 86 per cent of all admissions during 1961 were informal.[73]* The most dramatic change, however, was not in admissions for even in 1960 only 18 per cent of admissions had been compulsory. The biggest impact was felt in the composition of the mental hospital population. Despite the steady increase in voluntary admissions, the majority of patients resident in Scottish mental hospitals at the end of 1960 were there compulsorily. Following the Act, however, all

* 73 Table 11:1

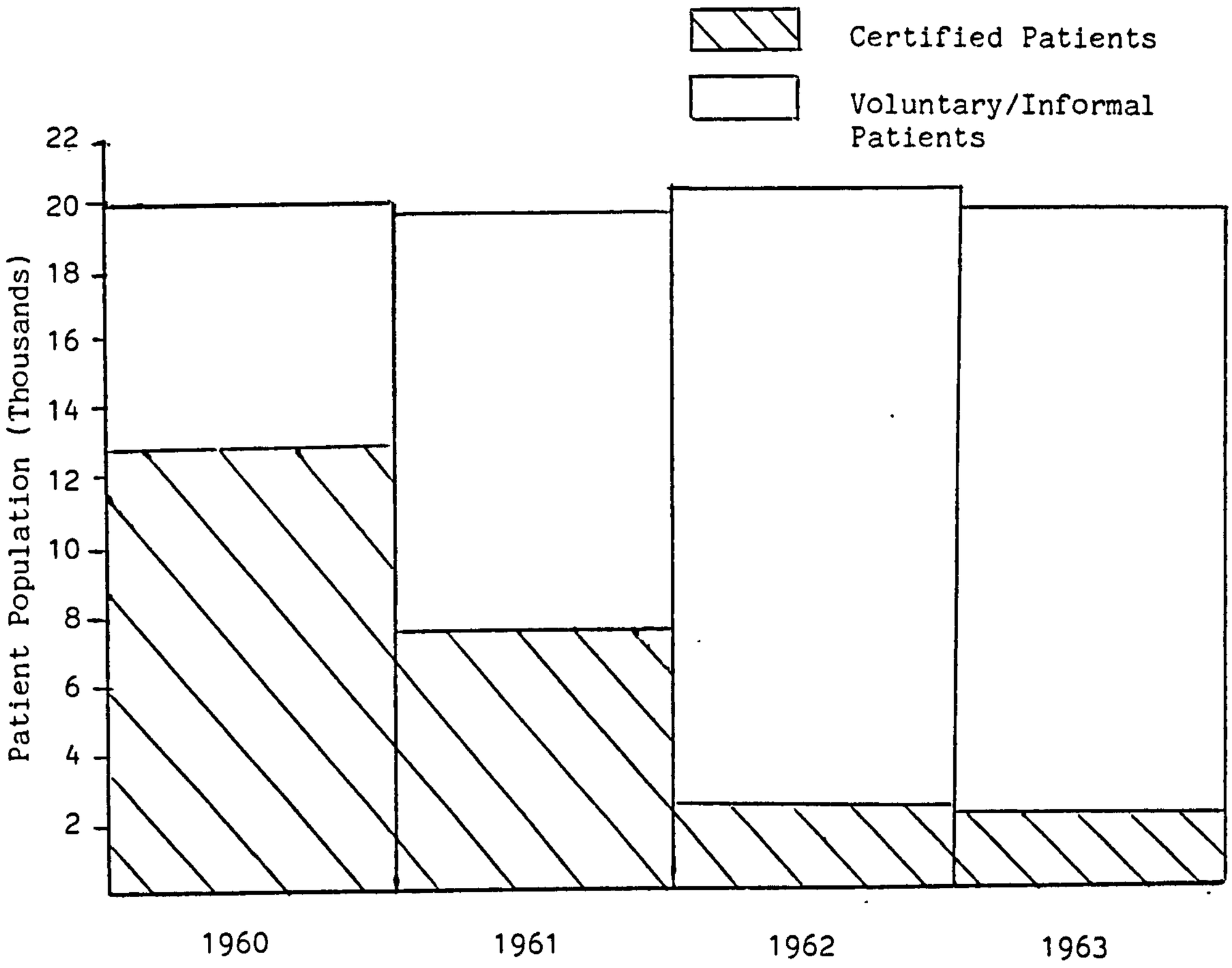
Table 11:2 The Status of Mental Patients Resident in Ordinary Mental Hospitals* at the End of Each Year, 1960-63

Year	Voluntary/Informal	Certified	Total
1960	6960	12958	19918
1961	12021	7651	19672
1962	17844	2315	20159
1963	17229	2206	19435

* Excluding the State Mental Hospital

Source: Annual Reports of the General Board of Control for Scotland and of the Scottish Home and Health Department

Figure 11.1 The Changing Mental Hospital Population, 1960-63



Source: Annual Reports of the General Board of Control for Scotland and of the Scottish Home and Health Department

Table 11:3 Patients in Mental Deficiency Institutions, 1958-63

A. Admissions*

Year	Certified	Informal	Total
1958	392	156	548
1959	445	234	679
1960	291	302	593
1961	143	361	504

* It is not clear whether these statistics include admissions to the State Institution

B. Patients Resident at the End of Each Year#

Year	Certified	Informal	Total
1958	5634	164	5798
1959	5772	344	6116
1960	5855	520	6375
1961	5336	1175	6511

These statistics do not include patients in the State Institution

Source: Annual Reports of the General Board of Control for Scotland and of the Scottish Home and Health Department

Table 11:4 Discharges and Re-Admissions of Mental Patients, 1960-63

A. Discharges*

Year	Voluntary/Informal	Certified	Total
1960	9008	1966	10974#
1961	10224	1274	11498#
1962	10857	1371	12228
1963	13427	681	14108

Excluding discharges from the State Mental Hospital

B. Re-Admissions*

Year	Total	Re-Admissions as a Percentage of Total Admissions
1960	5112	40
1961	6452	47
1962	7028	48

Source: Annual Reports of the General Board of Control for Scotland and of the Scottish Home and Health Department

* It is, with the exception of the discharges in 1960 and 1961, not clear whether these statistics include the State Mental Hospital.

mental hospitals were asked to review the status of their patients with a view to reclassifying them, and many patients - both certified and voluntary - were subsequently transferred to informal status.[74] The effect of the change in admissions and reclassification was startling. By the end of 1961, only 39 per cent of Scots mental hospital patients were compulsorily detained, compared to 65 per cent twelve months earlier.[75]* The momentum was maintained during 1962, when 89 per cent of admissions were informal;[76] and by the end of that year only 11 per cent of the mental hospital population was compulsorily detained.[77] The impact of the new provisions on mental defectives was less pronounced, perhaps because superintendents had more misgivings about informality in their case. There was, nevertheless, a parallel, if more modest, rise in the number of informal patients admitted to, and resident in, mental deficiency institutions.[78]* A review of the status of patients under guardianship also resulted in approximately one thousand patients being discharged from formal guardianship to informal supervision by the end of 1962.[79]

As had been generally expected, the introduction of informal status also resulted in an immediate increase in the number of patients leaving hospital, and in the number of re-admissions.[80]* The General Board was among those who were concerned about premature discharge, or 'too great a swing of the pendulum',[81] but it was difficult to see what could be done about it. The Act did provide for the emergency detention of an informal patient while the case was reviewed,[82] but too great a resort to these powers would defeat the whole object of informality. The development of better after-care would, it was hoped, tend to reduce the number of re-admissions in the longer term but, in the meantime, it seemed to be an unavoidable

*75 The numbers are shown in Table 11:2; see also Figure 11:1

*78 Table 11:3

side effect of the new informality.. Anxiety about what could, if taken to extremes, become a policy of 'discharge and be damned' persisted, but only time would tell whether the 'open door' of the 1950s would become the 'revolving door' of the 1960s.

The 1960 Act also modified the procedures which were to be used when compulsion was necessary.[83] For the first time, the same provisions would apply to both the mentally ill and defective; in both cases, the application for hospital admission or reception into guardianship, made by the patient's nearest relative[84] or the Mental Health Officer of the local health authority,[85] had to be supported by two medical 'recommendations' rather than certificates. These recommendations had to state the form of disorder - mental illness or deficiency, or both - from which the patient was suffering, and to state that the disorder required or was susceptible to medical treatment, and was of a nature or degree which warranted detention or reception. Most importantly they had to include a statement that the interests of the health or safety of the patient, or the protection of others, could not be secured otherwise than by detention or reception into guardianship. This provision was intended to ensure that compulsion would only be used as a last resort, in cases where no other means could provide the patient with the care or treatment that he or she needed.

There was, however, a crucial difference between these provisions and those of the English Act. It had abolished the necessity for judicial authority, but in Scotland the Sheriff's approval remained a prerequisite for compulsory detention in all but cases of 'urgent necessity'.[86] In fact, section 28 actually strengthened the Sheriff's powers; by empowering him to make such

enquiries and hear such persons (including the patient) as he saw fit before making his decision,[87] it made the granting of approval a judicial act rather than (as previously, in the case of 'lunatics') an administrative procedure.[88] The widely supported Dunlop Committee recommendation that the Sheriff should continue to be a participant in compulsory detention had been heeded, and the judicial bulwark against unjustifiable deprivation of liberty was retained, and even reinforced.

While the use of compulsory powers was generally limited, the Act placed further restrictions on their application to specific groups of patients. These were mental defectives who were not so severely handicapped as to be incapable of leading an independent life or of guarding themselves against serious exploitation, and persons whose mental illness was manifested only by 'abnormally aggressive or seriously irresponsible conduct'; in effect, the subnormal and psychopaths (although the Act, unlike the English Act, did not so designate them). These two groups could be subject to compulsory powers only if they were under twenty-one; and if they were compulsorily admitted to hospital or guardianship before that age they had to be discharged at age twenty-five, unless they were deemed likely to pose a danger to themselves or others.[89] The Act thus recognised, albeit in a somewhat circumspect way, the psychopathic group that had been the subject of so much debate. The age limits on the scope of compulsory action for these groups were a compromise; the aim was to provide treatment during the formative years while at the same time avoiding the long-term detention of those whose behaviour was merely a social nuisance or, in the case of the subnormal, of those who were, broadly, able to manage for themselves.

The 'de-designation' of the hospital service can also be seen

as part of the move to make treatment less formal. The Act did not continue the existing provisions for the designation of mental hospitals and mental deficiency institutions; in future, so far as the statutes were concerned, there would be no 'mental hospitals' or 'mental deficiency institutions', and patients could be treated in whichever hospital was most convenient or suitable. In reality, this did not mean that hospitals concerned wholly or primarily with the treatment of mental disorder would disappear. De-designation, however, allowed a greater degree of flexibility in the choice of institutional setting, and it also appeared likely that it would increase the contact between psychiatry and general medicine by stimulating the further development of psychiatric units in general hospitals. It was also a significant, if tacit, recognition that the mentally disordered were, in most cases, not so peculiar or dangerous as to require a special denomination of institution.

The Act provided for the dissolution of the General Board of Control for Scotland which, together with its predecessor - the General Board of Commissioners in Lunacy for Scotland - had exercised general superintendence over the service for the mentally disordered for over a century; its rights, liabilities and obligations were to be transferred to and vested in the Secretary of State. A new independent central body - the Mental Welfare Commission for Scotland - was to be created; its duties were to be entirely confined to safeguarding the interests of individual patients.[90] It would comprise at least seven and not more than nine commissioners, appointed by the Crown on the recommendation of the Secretary of State. At least one was to be a woman, at least three were to be medical practitioners - the 'Medical Commissioners' - and one was to be a member of the legal

profession. There were no other membership specifications. Non-medical members would thus be in the majority, and would control policy decisions.[91]

The Commission's role would be to generally exercise protective functions in respect of the mentally disordered. It was envisaged that it would fulfil this duty in three specific ways - through investigation, visitation and reports to the appropriate authorities. Firstly, the Commission was required to enquire into any case - compulsorily detained or informal - where irregularity - ill-treatment, deficiency in care or treatment, improper detention or damage to the patient's property - was suspected. Crucially, it had the right to discharge patients from compulsory detention or guardianship at any time. Secondly, the Commissioners were bound to visit regularly, and as often as they deemed necessary, patients detained in hospital or under guardianship, and to report on any deficiency in the care and treatment of any patient in the hospital, whether compulsorily detained or not. Finally, the Commission was required to bring to the attention of the appropriate authority - the Secretary of State, hospital authority or local authority - any matter necessary to secure the welfare of any patient suffering from mental disorder. The powers and duties of the M.W.C. were therefore much wider than those of the English Mental Health Review Tribunals, which were concerned only with questions of improper detention and which had no inspectorial or investigatory powers.

The Act, in establishing the Mental Welfare Commission and defining its responsibilities, had to perform a delicate balancing act. It was, on the one hand, necessary to maintain the new principle that the mentally disordered were as far as possible to be treated

like other patients and, on the other, to maintain effective safeguards in respect of the persons, interests and property of the mentally disordered. While the number of those compulsorily detained was, under the new legislation, likely to decrease, there was still a need to protect them. Indeed, as the Act recognised, informal status did not, by itself, eliminate the possibility of ill-usage or inadequate care, especially in the case of patients who might not realise the full implications of their status. On paper at least the Act appeared to have provided a structure which would permit the necessary integration while at the same time ensuring the security of those whose condition and, in some cases, legal status, made them vulnerable. Much would depend, however, on the calibre of those appointed to the Commission, the assiduity with which they exercised their powers, and the co-operation which they received from others involved in the service. But the Commission would at least not lack for experience, since Sir Hugh Rose, a long-time member of the General Board, was appointed as its first chairman.[92]

The Act reflected the recommendation of the Royal Commission and the Dunlop Committee that there should be more emphasis on community care. It was, however, more concerned to strengthen and expand existing powers, and to remove barriers, than to confer new ones. Local health authorities had, under section 27 of the N.H.S. (Scotland) Act 1947, power to provide informal supervision for mental defectives. The 1960 Act referred to this as one of a range of services which could be made (or might be required to be made) by L.H.A.s,[93] but made it clear that the L.H.A.'s general powers were not limited to those conferred by the section. Under section 29 of the National Assistance Act L.H.A.s had powers to make arrangements

for promoting the welfare of those substantially and permanently handicapped by illness, injury or deformity, and the 1960 Act made it clear that the provision applied to persons suffering from mental disorder of any kind.[94] Services could be provided for the mentally disordered under either health or welfare powers, as might be most convenient. The Act thus gave local authorities more freedom of action, but without making it clear in what precise direction they should move.

The Scottish Health Services Council's Standing Advisory Committee on Local Authority Services was given the task of providing the necessary clarification. This body, which reported in March 1961, stressed that the object of every local authority must be to expand its mental health services to the point at which no person need be resident in hospital who did not require it. It also detailed the wide range of amenities - including nurseries, junior and senior occupation centres, short-stay residential accommodation, hostels and social clubs - which it believed were necessary to ensure that this aim was met.[95] Similar recommendations had been made before, but the difference now was that, while the Committee had been deliberating, the Secretary of State had used his powers of direction to convert the local authorities' discretionary powers to make arrangements for the prevention, care and after-care of the mentally disordered into a duty.[96] Local authorities, with the guidance of the S.A.C. report, began to draw up proposals for carrying out these new obligations, which were further added to when, in 1962, the authorities' powers to provide welfare services for the mentally disordered were similarly converted into a duty.[97]

All the provisions of the Act which were not already in

operation - including the new compulsory procedures and the creation of the Mental Welfare Commission - came into force on 1 June 1962. Thus a series of Acts, dating back to the 1857 Lunacy Act and including all the nineteenth-century Lunacy Acts and the 1913 Act, were repealed, and more than a score of others were amended. The process of implementation went on with the continued reclassification of patients and the drawing up of L.H.A. proposals for community care; most authorities had taken account of the S.A.C. report, and a variety of community amenities were being planned and provided.[98] Regulations were drawn up and memoranda, circulars and leaflets explaining the relevant provisions of the Act were issued to hospitals, local authorities, G.P.s and voluntary associations.[99] The immediate upheaval was almost over by 1963 when, following the completion of reclassification, the marked reduction in the number of compulsory patients levelled off.[100*]

The change which had taken place in three years was remarkable. At the end of 1960, almost two-thirds of the mental hospital population had been subject to compulsory detention; by the end of 1963, the proportion was a little over one-ninth. In the same period, the number of patients in mental hospital of their own accord had almost trebled.[101*] This was the most obvious impact of the new legislation: the full effect of some of its other provisions, such as the creation of the M.W.C. and the expansion of community care, would, by their nature, take some time to be felt. Indeed, the longer-term consequences of the Act were rather unpredictable. The attitude and enthusiasm of all those involved in the service - including the medical profession, local authorities, voluntary organisations and the patients themselves - would be vitally important. Much would also

* 100 Table 11:2

* 101 Table 11:2

depend upon the financial and man-power resources devoted to the service, and the general priority afforded to it. Underlying all these factors was public opinion. The D.H.S. in 1961 breathed an almost audible sigh of relief that, in the short term at least, the 'gloomy forebodings' of those who envisaged hordes of dangerously deranged ex-patients let loose upon the community had not been fulfilled.[102] Mental health interests, however, were still conscious of the adverse effect that an untoward incident involving a mental patient discharged under the new informal provisions might have on the brittle public tolerance of the mentally disordered. The Act provided a new framework for the service, the skeleton of a preventive and comprehensive institutional and community service. The flesh upon the bare bones, however, depended upon many factors which legislation alone could not determine or control.

Conclusion

In the introduction to this thesis it was stated that the history of mental health policy in Scotland was both an illustration of developments which took place on a U.K.-wide basis, or an even wider one, and also the history of changes which took place within one country. There were many parallels between the evolution of the Scottish and English services. The creation of the mental deficiency service, the disruption of World War One, the trends of the inter-war years - 'de-pauperisation', the increased emphasis on early and voluntary treatment, and the new therapies - the impact of the Second World War, the establishment of the N.H.S., the innovations of the 1950s and the introduction of the principle of informality were all common to both countries. The broad outlines of policy, and some of the details, were very similar. This was partly because the two services were affected by many of the same political, economic, medical, theoretical and even military factors and forces, which meant that those involved in the service shared many of the same ideas, attitudes, aspirations and problems. It was also, however, the result of the extent to which Scotland's power of self-determination was circumscribed by the structures of government. The effect of this lack of autonomy was perhaps most evident during the negotiations leading to the creation of the N.H.S.; the proposed exclusion of the mental health service from the new service was generally deplored in Scotland, but it was not until the Minister in London changed his mind that the Scottish mental health service was included within the N.H.S.

However, it would be inaccurate to characterise the Scottish service as an anglicised service with a few relatively insignificant tartan trimmings. Within the broad parameters of policy there were

many real differences in the development of the services north and south of the border. The 1959 (English) and 1960 (Scottish) Mental Health Acts were a prime example. In outline their provisions were very similar but in detail - and particularly in the rejection of medical omnipotence which was inherent in the retention of the Sheriff's role in the committal process - the Scottish legislation was 'very different in outlook and fundamental principles'.[1] The same was true in many other areas of provision; the Scottish educational legislation of the 1940s, for example, demonstrated a markedly different attitude towards the respective place of education and medical intervention in the training of the mentally handicapped and in the child guidance service. The balance struck in Scotland between institutional and non-institutional care was, because of the widespread use of the boarding-out system, for much of the period quite different to that in England. The provisions of the Six Months Certificate, and observation wards, as well as the generally less limited opportunities for voluntary asylum treatment, also meant that, until 1930, the Scottish service was more 'progressive' than its English counterpart.

No one consistently Scottish thread can be detected in this diversity. There is no single outstanding factor that can be pointed out as the reason for them or as the 'trademark' of the Scottish service: the diversity was due to the interplay of long-standing, and more modern, legal and administrative differences, to geography and demography, to economic, political, social and cultural factors. For while the broad contours of policy were frequently decided elsewhere, the development and implementation of the Scottish mental health service was to a large extent moulded by, and in some instances impeded by, Scottish traditions, experiences, structures and attitudes.

So far as developments within Scotland were concerned, it would be difficult to delineate all the differences between the mental health service in 1908 and in 1960. At the most basic level, the scope of the service was much broader. While the number of patients under care for mental illness at the end of 1960, in a somewhat larger total population, was, at just over 20,000, not much larger than the nearly 18,000 known lunatics in January 1908, the service was, because of the 9,000 mental defectives and the greatly increased number of patients using hospital facilities for short periods, a much larger service in 1960.[2] The framework of this larger service had - in terms of organisation, administration and finance - changed almost beyond recognition.

The treatments available - and the variety of settings in which they took place - had also been undreamt of in 1908. E.C.T., new forms of chemotherapy, insulin coma therapy, leucotomy, psychotherapy, group, occupational and work therapy were available not only in traditional institutions but, in various permutations, in clinics at mental hospitals, in-patient and out-patient departments at general hospitals, day hospitals, night hospitals, child guidance clinics, occupation and employment centres: in this sense also the service was more comprehensive. Within institutions pauper lunacy was, by 1960, a fading memory. The majority of patients were, at least when the provisions of the 1960 Act took effect, no longer subject to formal legal procedures, thus realising the aspirations of those psychiatrists who, thirty years before, had hoped that 'some day in the future', voluntary patients would be allowed to enter a mental hospital with 'no more formality than that required in the case of the ordinary patient admitted to a general hospital'.[3] The disappearance of

blanket certification, with all its implications for the service, the institution and the individual, was perhaps the single most striking change that had taken place.

In other instances, however, change was less concrete and more questionable. Throughout the period, and particularly from the 1920s onwards, there was an almost obsessive insistence upon the increasingly positive atittude of the public towards mental disorder and those who suffered from it. The difficulties inherent in demonstrating that this was occurring have already been described. There were indications of change; in particular, the increasing number of voluntary patients and the demand for out-patient facilities showed that the stigma traditionally associated with mental disorder did not deter a growing number of patients from seeking treatment. The language used to describe mental institutions and their patients was also suggestive of change; terms like 'lunatic', 'mental defective', 'idiot', 'imbecile' and 'asylum' had, by the end of the period, vanished from the statute books, and it is, for example, difficult to imagine someone opening a mental hospital in 1960 describing it, as Lord Rosebery did when opening Bangour in the 1900s, as a 'tomb of the intellectually dead'.[4] However, these trends do not constitute a reliable yardstick by which shifts in public opinion can be measured: voluntary and extra-asylum treatment had not been available for the vast majority of patients to accept or reject in the early part of the period, and terminological alterations were hardly conclusive proof of a real change. It is virtually impossible to provide incontrovertible evidence of the alleged improvement, still less the transformation, of public attitudes.

It was generally believed that much of the stigma of mental

disorder was due to ignorance of its causes. This is very debatable; recognition of the aetiology of a condition does not necessarily alleviate the stigma which attaches to it and may even increase it. But in the case of mental illness and handicap there was always some degree of uncertainty about its causes, at both a popular and scientific level, and there was certainly a general consensus throughout the period that it was the mystery or mystique associated with mental disorder which was one of the primary causes of the public attitude towards it. In the early part of the period echoes of the perceived link between mental disorder and witchcraft or occult forces were still detectable: possession by spirits as a cause of mental disorder had, as Dr Robertson remarked in 1916, 'the double merit of antiquity and simplicity to support it'.[5] Subsequently the causation was sought in genetics, in childhood experiences, in physical disturbances, in environmental influences like the stresses of urban living and the wrong sort of education. Even in 1961, however, the Department of Health still had to admit that 'the cause of many forms of mental disorder remains obscure'.[6] In this respect progress had been rather disappointing.

The location within which much treatment continued to take place was also relatively unchanged. Some new mental deficiency accommodation had been provided and many institutions for the mentally ill had been remodelled and extended. Nevertheless the mental hospitals of 1960 were, to a large extent, the asylums of 1908. The route by which some patients arrived in the institutions also formed an unbroken thread. The frequency with which certification was employed and, to a lesser extent, the procedures which it involved had changed. But the concept that compulsion must be used in cases where

the patient's welfare or the well-being of the public demanded it was as firmly entrenched in psychiatry in 1960 as it had been in 1908 or, indeed, in 1857. The bete noire to anti-psychiatrists, and an unfortunate but necessary safeguard to others, the retention of the principle and practice of compulsion continued to differentiate the mental health service from the rest of the health service.

There were therefore areas in which the changes had been dramatic and areas in which concepts and practices formed an almost uninterrupted chain. In still more instances the movement appeared to be cyclical. As the General Board remarked in its valedictory report for 1961, 'quite a number of ideas which are generally regarded as being of modern origin had actually been put into practice many years ago'.[7] Many twentieth-century 'innovations' - including occupational therapy, the open-door and the therapeutic community, psychiatric units in general hospitals and community care - did carry strong echoes of the past; and even informal treatment was not entirely new, since mental patients in the observation wards first opened before the turn of the century were, legally, in the same position as patients in other wards of the hospital.

The view that the mental health service moved like a pendulum, and that one generation resurrected and recycled (sometimes with new motives and justifications) that which had been tried and abandoned by previous generations, therefore, has some merit. But the cyclical model should not be used too glibly. The degree of continuity with, or duplication of, the past should not be underestimated, but neither should it be exaggerated. Modern concepts and practices were rarely exact replicas of their ancestral forms, and the context in which they were introduced - or re-introduced - was often very different. A

strict adherence to the regurgitation perspective is as simplistic as the argument that everything had changed or that nothing had changed.

Anti-psychiatry, then, would characterise the period 1908-60 as one when the tentacles of psychiatry as a tool of social control extended ever further, while what might be called 'pro-psychiatry' would argue that it saw the improvement of the lot of the mentally disordered. The period may have seen the increased 'psychiatricisation' (to use an ugly term) of deviation. But it also saw (to use equally ugly terms) its 'de-pauperisation' and, to a large extent, its 'de-certification'. It is impossible for those who have not undergone the processes to fully understand the experiences of pauperisation and certification, but all the evidence suggests that they superimposed feelings of shame and disgrace upon those who were already distressed. The effect of the changes which took place in the period on the vast majority of patients - who were no longer entered on a poor roll as a pauper, and subjected to certification and judicial process in order to receive, often at a late stage, a very second-class service - should not be discounted in the interests of proving an interesting theory. If 'progress' in the Scottish mental health service in the years 1908-60 is to be measured by the quasi-Benthamite yardstick of that which causes the least possible unhappiness to the greatest number, then progress there had been.

Introduction: Footnotes

1. F.J. Rice, Madness in Industrial Society, unpublished Ph.D. thesis, University of Strathclyde (1981). Rice deals with the origins and early growth of the organisation of insanity in nineteenth-century Scotland, with particular reference to the period 1830-70.

2. D.K. Henderson, The Evolution of Psychiatry in Scotland (1964).

3. Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940).

4. Andrew T. Scull, 'The Social History of Psychiatry in the Victorian Era', in Scull (ed.), Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era (1981), p. 5 [hereinafter cited as Madhouses].

5. In Lunacy, Law and Conscience 1744-1845: The Social History of the Care of the Insane (1955) and Mental Health and Social Policy 1845-1959 (1960).

6. Tom Butler, Mental Health, Social Policy and the Law (1985), p. 209.

7. Szasz's publications include Ideology and Insanity: Essays on the Psychiatric Dehumanisation of Man (1973), The Manufacture of Madness: A Comparative Study of the Inquisition and Mental Health Movement (1973) and The Myth of Mental Illness: Foundations of a Theory of Personal Conduct (1981).

8. Foucault's Histoire de la Folie was translated into English as Madness and Civilisation: A History of Insanity in the Age of Reason (1967).

9. Scull, Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England (1979).

10. Andy Treacher and Geoff Baruch, Psychiatry Observed (1978) and 'Towards a Critical History of the Psychiatric Profession' in David Ingleby (ed.), Critical Psychiatry: The Politics of Mental Health (1981).

11. D. Ewins, The Origins of the Compulsory Commitment Provisions of the Mental Health Act (1959), unpublished M.A. thesis, University of Sheffield (1974).

12. P. Susan Penfold and Gillian A. Walker, Women and the Psychiatric Paradox (1984).

13. Elaine Showalter, 'Victorian Women and Insanity' in Scull, Madhouses.

14. Scull, Madhouses, p. 5.

15. Constance M. McGovern, 'The Myths of Social Control and Custodial Oppression: Patterns of Psychiatric Medicine in late Nineteenth Century Institutions', Journal of Social History 20, No. 1 (Fall 1986), pp. 3-23.

16. Vieda Skultans, English Madness: Ideas on Insanity 1580-1890 (1979), p. 4.

17. In Ideology and Insanity Szasz argues that psychiatric patients have replaced Jews (and others) as society's scapegoats and describes compulsory hospitalisation as a crime against humanity.

18. Easterbrook, op. cit., p. 297.

19. Treacher and Baruch in Ingleby, op. cit., p. 120.

20. The title of a chapter in Ideology and Insanity.

21. David Stafford-Clarke, Psychiatry Today (1952), p. 10.

22. Shulamit Ramon, Psychiatry in Britain: Meaning and Policy (1985).

23. Treacher and Baruch in Ingleby, op. cit., p. 122.

24. Ramon, op. cit., p. 317.

Chapter 1 : Footnotes

1. The other duties of this official are described later.

2. Sheriffs were the highest judicial officers of counties. However, their functions were largely restricted to considering appeals from the judgements of the Sheriffs-Substitute who, in practice, dealt with lunatics.

3. It was, for example, illegal (under the terms of the Lunacy (Scotland) Act 1866) for the medical superintendent or medical officer of an asylum to grant a certificate (other than a Certificate of Emergency) for the reception of a private patient into the asylum in which he was a doctor; the provision was designed to prevent certification for pecuniary motives.

4. At Edinburgh University, for example, psychiatry did not become a compulsory part of the medical curriculum until the mid-1940s; it was previously a discretionary option. (One Hundred and Thirty Fourth Annual Report, For the Year 1944, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 7-8.

5. In England, the judicial authority - the magistrate - was (under the terms of section 6 of the Lunacy Act 1890) empowered to make enquiries regarding the alleged lunatic, and was expected to form an independent judgement of his mental fitness or unfitness.

6. The procedure, however, was very cumbersome: the prospective patient had to make a statement of his desire to submit to treatment before the Sheriff, and produce a doctor's certificate and the written assent of an asylum superintendent, before the Sheriff could grant an order for his reception as a voluntary patient.

7. In England it was illegal for a patient to receive voluntary treatment in an asylum erected by rate-payers.

8. The question of whether 'certifiable but willing' patients were excluded from voluntary treatment was to be hotly debated in the years after World War One, but attracted little attention before it.

9. In 1907, for example, the General Board was particularly disturbed by a case in which a woman presented herself for voluntary treatment at the Aberdeen Royal Asylum but in the absence of the Board's sanction was turned away, only to commit suicide the next day. The Board suggested that in such cases physician-superintendents should make some temporary arrangements to secure the applicant's safety until sanction was obtained. (S.R.O.MC1/11 (1907— 09), Minute Books of the General Board of Commissioners in Lunacy for Scotland, 9 July 1907.) It is not clear why the Superintendent did not, for example, attempt to detain the woman under the Emergency Certificate.

10. The financing of the service is discussed later.

11. Table 1:1.

12. The Deputy Commissioners' primary function was the visitation of patients in private dwellings.

13. The Legal Commissioners, unlike the Medical Commissioners, were unpaid.

14. Under the terms of the 1862 Lunacy Act the Board was required to hold monthly meetings.

15. The Local Government Board comprised both ex-officio members - including the Secretary for Scotland - and Crown appointees.

16. Grandchildren, for example, were required to support their grandparents, and a son who inherited property was bound to support his siblings (M.A. Crowther, 'Family Responsibility and State Responsibilitv in Britain Before the Welfare State', Historical Journal 25, No. 1 (March 1982), pp. 132-33).

17. Under the terms of the Poor Law (Scotland) Act 1845 and the Lunacy (Scotland) Act 1857.

18. Under the terms of the 1866 Act, the parish council was empowered to direct the removal of any lunatic who was not dangerous: the asylum superintendent was bound to comply unless, on the grounds that the lunatic was dangerous to himself or others, the General Board prohibited discharge at the superintendent's request.

19. A pauper lunatic was defined by section 1 of the Lunacy (Scotland) Act 1862 as any lunatic towards the expense of whose maintenance an allowance was given or made by any parish council.

20. In 1906, for example, it was estimated that almost half of all registered patients resident in private dwellings were congenital imbeciles. (Forty-Ninth Annual Report of the General Board of Commissioners in Lunacy for Scotland [for the year ended 1 January 1907], PP 1907, xxx, Cd 3520, p. li.)

21. It comprised a fixed contribution of £90,000 (under section 22 of the Local Government (Scotland) Act 1889) supplemented by a further sum of £25,000 (under section 2 of the Education and Local Taxation Account (Scotland) Act 1892).

22. Parish councils spent £402,254 on pauper lunacy during the year ended 15 May 1909. Repayments amounted to £20,246. (Fifty-Second Annual Report of the GBCLS [for the year ended 1 January 1910], PP 1910, xli, Cd. 5315, p. lvi.) Five years earlier, in the year ended 15 May 1904, expenditure had been £370,474, and repayments £21,425. (Forty-Seventh Annual Report of the GBCLS [for the year ended 1 January 1905], PP 1905, xxxvi, Cd. 2504, p. lix.)

23. The number of registered pauper lunatics on 1 January 1909 (shown in Table 1:2) was more than 2,800 higher than the number

on 1 January 1900. The average daily cost of asylum treatment rose from 1s 5d to 1s 6d in the same period (Annual Reports of the GBCLS for the years ended 1 January 1900, 1909 and 1910, passim).

24. Fifty-Second Annual Report of the GBCLS [for the year ended 1 January 1910], pp. lvi-lix and Appendix A, Table xxvi, p. 60.

25. Fifty-Fourth Annual Report of the GBCLS [for the year ended 1 January 1912], PP 1912-13, xxxix, Cd 6211, p. lxxii.

26. Nor was the patient always taken to the nearest asylum. Under long-standing contracts paupers from Orkney, for example, were accommodated in the Edinburgh Royal Asylum even though there were much nearer asylums in Inverness and Aberdeen.

27. Non-institution provision is described later.

28. The facilities available for treatment without certification and judicial order are discussed later.

29. They were: Shetland, Orkney, Caithness, Inverness, Elgin, Banff, Aberdeen County, Aberdeen City, Kincardine, Forfar, Dundee, Perth, Stirling, Fife and Kinross, Edinburgh, Leith, Midlothian and Peebles, Haddington, Roxburgh, Glasgow, Govan, Lanark, Renfrew, Argyll, Bute, Ayr and Dumfries (Forty-Eighth Annual Report of the GBCLS [for the year ended 1 January 1906], PP 1906, xxxix, Cd 3021, pp. xlviii-xlix).

30. As in the case of Orkney and the Edinburgh Royal Asylum, some contracts were made with distant asylums. The Crichton Royal Institution received paupers from the Counties of Dumfries and Wigtown and the Stewartry of Kirkcudbright under a special provision of the 1857 Lunacy Act (section 60).

31. In Edinburgh for example the school board established classes for mentally defective children at Albion Road and Milton House schools in 1907, and in 1908 opened a special school at Willowbrae for mentally and physically defective pupils (H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 (1974), p. 82).

32. Chartering, however, did not always coincide with the opening of the asylum. The asylum in Glasgow opened in 1814 but did not receive its Royal Charter until 1824 (Frank Rice, 'Care and Treatment of the Mentally Ill', in Olive Checkland and Margaret Lamb (eds.), Health Care as Social History: the Glasgow Case (1982), p. 62). Conversely, the Edinburgh asylum was chartered before its opening (One Hundredth Annual Report of the Royal Edinburgh Asylum For the Year 1912, p. 1).

33. There is, however, a considerable difference of opinion on this point between Rice, who suggests that Edinburgh was the only Royal asylum to receive public funds (Rice, op. cit., p. 62) and

the General Board, which stated that Aberdeen, Dundee, Glasgow and Montrose, as well as Edinburgh, were erected out of funds which included contributions from parochial sources (Fifty-First Annual Report of the GBCLS [for the year ended 1 January 1909] PP 1909, xxxii, Cd. 4619, pp. xxvii-xxviii).

34. Table 1:3.

35. Tables 1:2 and 1:3.

36. Table 1:3.

37. The district asylums were (with their date of opening): Elgin (1858?), Argyll and Bute (1863), Perth (1864), Inverness (1864), Banff (1865), Fife and Kinross (1866), Haddington (1866), Roxburgh (1867), Stirling (1869), Ayr (1869), Midlothian (1874), Glasgow Woodilee (1875), Kirklands (1881), Lanark (1895), Glasgow Gartloch (1896), Dundee (1903), Aberdeen (1904), Edinburgh (1904), Renfrew (1909) and Paisley (1909).

38. They were also, of course, numerically the most common form of asylum.

39. Table 1:3.

40. Table 1:3.

41. Table 1:3.

42. Patients were admitted on the application of the Inspector of Poor and a statement from the medical officer of the parish, or from the institution from which the patient had been discharged. If the patient was already certified, a single further certificate was required. If not, then the normal two were necessary (Section 4, 1862 Lunacy Act).

43. Parochial asylums came into existence under section 1 of the Lunacy Amendment Act 1858: the Act expired after five years, but licences granted under it were renewed by the 1862 Lunacy Act.

44. Lunatic wards, by their nature, provided only care, not treatment.

45. The Local Government Board was statutorily responsible for observation wards. The memorandum which it and the General Board drew up also made stipulations regarding ward space, registers, medical attendance (a resident poorhouse medical officer was required for the establishment or continuation of an observation ward with more than sixteen beds), and nursing care (Thomas Ferguson, Scottish Social Welfare 1864-1914 (1958), p. 505). Although patients were not, technically, under the jurisdiction of the General Board, its Commissioners did visit the wards 'from time to time' (Forty-Eighth Annual Report of the GBCLS [for the year ended 1 January 1906], p. liii).

46. Although because of the short stay policy of the wards they were

intensively used; at the Eastern District Hospital, for example, 4,835 patients were treated in the observation wards between 1904 and 1912 (Ferguson, op. cit., p. 506).

47. In 1911, the Institution's title was altered to the more 'modern' one of 'Baldovan Institution for the Treatment and Education of the Feeble-Minded' (S.R.O.MC1/12 (1910 - April 1914), Minute Books of the GBCLS, 18 October 1911).

48. Forty-Seventh Annual Report of the GBCLS [for the year ended 1 January 1905], p. xlii.

49. The numbers in the training schools grew from 445 (199 private and 246 pauper) on 1 January 1908 to 580 (150 private and 430 pauper) on 1 January 1913 (Fiftieth Annual Report of the GBCLS [for the year ended 1 January 1913] PP 1913, xxxiv, Cd. 6825, Table, p. vi).

50. The circumstances which brought a private lunatic in a private dwelling under the supervision of the Board were: if he was kept for profit (unless he was a patient certified under the Six Months Certificate); if, whether kept for profit or not, he had been insane for more than a year and was subjected to compulsory confinement to the house or restraint or coercion, or was harshly or cruelly treated; or if he possessed property which had been placed under curatory by a Court of Law. The Board thus had no official knowledge of 'a large number' of insane persons living at home under their natural guardians (Fifty-First Annual Report of the GBCLS [for the year ended 1 January 1909], p. xliii-xliv).

51. Table 1:4.

52. Tables 1:2 and 1:4.

53. The system was never adopted in England or, more surprisingly given the similarities between the lunacy systems of Scotland and Ireland, in Ireland. Finnane attributes its lack of popularity in Ireland to the authorities' 'suspicion of innovation', possible public opposition, and the British perception that the lawlessness of the Irish and the lack of suitable houses would make its introduction impracticable (Mark Finnane, Insanity and the Insane in Post-Famine Ireland (1981), p. 72).

54. In 1913 the aliment was 7s per week (Fifty-Sixth Annual Report of the GBCLS [for the year ended 1 January 1914], PP 1914, xll, Cd. 7404, p. xlix).

55. As described in note 20.

56. In December 1906, for example, there were 544 licensed houses in Scotland - 344 contained two patients, 117 three patients, and 53 four patients. 778 of the 1184 patients resident in them were female (Forty-Ninth Annual Report of the GBCLS [for the year ended 1 January 1907], Table, p. xlviii).

57. Table 1:4 shows the number of paupers in private dwellings: the 2780 paupers in private dwellings on 1 January 1908 represented a rise of 111 from the same date in 1901. The number of paupers resident with unrelated guardians - those who, strictly, were boarded out - had increased from 1,682 in 1901 to 1,809 in 1908 (Fifty-Second Annual Report of the GBCLS [for the year ended 1 January 1910], Table, p. xli).

58. In 1909, for example, the cost of keeping a pauper lunatic in a private dwelling varied between 8¼d and 1s 3½d per day, while the cost of maintenance in an asylum was 1s 2d - 1s 10d per day (ibid., p. lix).

59. Forty-Eighth Annual Report of the GBCLS [for the year ended 1 January 1906], p. xlviii.

60. Fifty-Third Annual Report of the GBCLS [for the year ended 1 January 1911] PP 1911, xxxv, Cd. 5720, p. xlvii.

61. Ibid., p. xlvii.

62. In 1909, for example, only 5 per cent of lunatics in the parish of Falkirk were boarded out, compared to 48 per cent and 34 per cent in the nearby parishes of Kilsyth and Grangemouth respectively (Fifty-Second Annual Report of the GBCLS [for the year ended 1 January 1910], p. xxxiii).

63. Fifty-Third Annual Report of the GBCLS [for the year ended 1 January 1911], Appendix C, p. 159.

64. Fifty-Sixth Annual Report of the GBCLS [for the year ended 1 January 1914], p. xlix. Female patients, the Board felt, were ideally accommodated with 'labouring people' in small villages (ibid., p. xlix).

65. Forty-Eighth Annual Report of the GBCLS [for the year ended 1 January 1906], p. xlvii, and Fifty-Fourth Annual Report of the GBCLS [for the year ended 1 January 1912], Appendix C, p. 147.

66. The principle was established in 1864 by Sir Arthur Mitchell, then Deputy Commissioner in Lunacy (Fifty-Sixth Annual Report of the GBCLS [for the year ended 1 January 1914], p. lxxx).

67. Fiftieth Annual Report of the GBCLS [for the year ended 1 January 1908], p. xliii.

68. Visitation by officers of the General Board, local medical officers and Inspectors of Poor meant that a minimum of eight annual visits were made to boarders, but in licensed houses shared by two parishes a maximum of sixteen was possible (Forty-Ninth Annual Report of the GBCLS [for the year ended 1 January 1907], p. xlix).

69. In 1910, for example, a widow with a licensed house containing two male patients had her licence revoked when she became

pregnant. Following representations by the Inspector of Poor, however, she was allowed to continue as the guardian of one of the boarders (S.R.O.MC1/12 (1910 - April 1914), Minute Books of the GBCLS, 28 December 1910 and 25 January 1911).

70. In cases where it was found that boarders were excluded from the family table at mealtimes, for example, the guardians were warned that the patients would be removed (Fiftieth Annual Report of the GBCLS [for the year ended 1 January 1908], p. xliii).

71. Fifty-Fifth Annual Report of the GBCLS [for the year ended 1 January 1913], p. liv, and Fifty-Fourth Annual Report of the GBCLS [for the year ended 1 January 1912], Appendix C, p. 150.

72. In 1896 the first serious assault by a boarder for thirty-eight years occurred when one killed a child with a knife, while in 1902 a patient killed his guardian (who was also his cousin) (Fifty-Sixth Annual Report of the GBCLS [for the year ended 1 January 1914], p. lxxxi).

73. Forty-Eighth Annual report of the GBCLS [for the year ended 1 January 1906], p. xlviii, and Fifty-First Annual Report of the GBCLS [for the year ended 1 January 1909], p. xlvii.

74. Many guardians maintained that the presence of the boarder did their children good and made them more kindly and considerate towards suffering (Fifty-First Annual Report of the GBCLS...p. xlix).

75. Dr. John Macpherson, the Commissioner who investigated the case, concluded that much of the wide publicity which surrounded the case was unfair, and that the alleged misconduct - which involved assault, sheep-worrying and general hooliganism - had been greatly exaggerated (Ferguson, op.cit., pp. 529-30).

76. S.R.O.MC1/12 (1910 - April 1914), Minute Books of the GBCLS, 27 November 1912.

77. Ibid., 15 January 1913.

78. Ibid., 23 October 1911.

79. Ibid., 27 December 1911.

80. The term 'eugenics' was coined in the 1880s by Francis Galton, the father of British eugenism. He defined it as 'the science of improving stock' (Lyndsay A. Farrall, 'The History of Eugenics: A Bibliographical Review', Annals of Science 36, No. 2 (March 1979), pp. 111-12).

81. Farrall, The Origins and Growth of the English Eugenics Movement 1865-1925 (1970), p. 209.

82. For example, Dr. Easterbrook, Physician-Superintendent of the Crichton Royal Institution, was convinced that 'the predisposing constitutional factor' was a major factor in mental illness

(Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), p. 361), Dr. Robertson, Physician-Superintendent of Edinburgh Royal Asylum,felt that among the causes of insanity 'hereditary influences occupied the most important place' (One Hundred and First Annual Report of the Royal Edinburgh Asylum For the Year 1913, p. 13), and Dr. Reid of Aberdeen Royal Asylum asserted that, except in cases of organic brain disease, heredity played 'the chief part in the causation of mental disorder' (Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1910, p. 26).

83. Annual Report ... Aberdeen Royal Asylum ... 1910, p. 27.

84. In the five years up to 1912, for example, 19 per cent of admissions to the Edinburgh Royal Asylum were because of general paralysis (One Hundredth Annual Report of the Royal Edinburgh Asylum For the Year 1912, pp. 12-13). It was also responsible for a startling 45 per cent of male deaths in the institution during the period (ibid., p. 13). The disease was more common in urban areas, and Edinburgh may have had a particularly high incidence of it (ibid., p. 14). Nevertheless, in 1912, general paralysis was responsible for 14 per cent of all deaths in Scots asylums, whereas, in the country as a whole, the figure was approximately 0.3 per cent (Fifty-Fifth Annual Report of the GBCLS [for the year ended 1 January 1913], p. lxvi).

85. As the General Board implied in its emphasis on the need to 'protect' young girls and women against the risk of pregnancy (Fifty-Sxith Annual Report of the GBCLS [for the year ended 1 January 1914], p. lxxxi).

86. Easterbrook, op.cit., p. 313.

87. Ibid., p. 297.

88. Forty-Eighth Annual Report of the GBCLS [for the year ended 1 January 1906], p. xiii, and Forty-Ninth Annual Report of the GBCLS [for the year ended 1 January 1907], pp. xiii-xiv.

89. He drew attention to the effects of demographic changes such as the declining birth-rate, the increase in the numbers of the elderly, and emigration (One Hundred and First Annual Report of the Royal Edinburgh Asylum For the Year 1913, pp. 16-20).

90. Quoted in Ferguson, op.cit., pp. 529-30. Macpherson believed that the writer of the exposé about Iona - a C.P. Mudge - was so obsessed by eugenics that he exaggerated and distorted events to suit his theories.

91. Mudge, paraphrased in Ferguson (ibid., pp. 529-30).

92. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1910, p. 27.

93. Royal Warrants to the Royal Commission on the Care and Control of

the Feeble-Minded (9 September 1904 and 2 November 1906) in the Report of the Royal Commission on the Care and Control of the Feeble-Minded, Vol. VIII (1908), PP 1908, xxxix, Cd. 4202, pp. xvi-xxiii.

94. Ibid., Part XII, Scotland, paras. 927-28.

95. Ibid., Part XII, passim.

96. Ibid., paras. 1000-1004 and Recommendation III.

97. Ibid., para. 1004 and Recommendations I and VI.

98. Ibid., paras. 1006-1011 and Recommendations VII, X and XI.

99. Ibid., Recommendation VIII.

100. Ibid., Recommendation II.

101. Fifty-First Annual Report of the GBCLS [for the year ended 1 January 1909], pp. lxxi-lxxv.

102. Separate Report by Rev. Prebendary H. Russell Wakefield, Mr. Francis Chandler, Mr. George Lansbury and Mrs. Sidney Webb [hereinafter cited as the Minority] in the Report of the Royal Commission on the Poor Laws and Relief of Distress (1909), PP 1909, xxxvii, Cd. 4499, p. 897.

103. The Minority, in the Royal Commission on the Poor Laws and Relief of Distress Report on Scotland (1909), PP 1909, xxxviii, Cd. 4922, pp. 263-64.

104. Ibid., pp. 263-64.

105. As Sutherland points out, it was engaged, among other things, in taking on the House of Lords, reorganising the army and fending off the suffragettes (Gillian Sutherland, Ability, Merit and Measurement: Mental Testing and English Education 1880-1940 (1984), p. 41).

106. Part I (sections 1-18) dealt with the powers and manner of dealing with defectives, Part II (sections 19-23) with the establishment of new central and local authorities to replace the General Board and district boards, Part III (sections 24-42) with the powers of the new authorities and the provision of institutions for defectives, Part IV (sections 43-50) with legal proceedings etc. relating to defectives, Part V (sections 51-75) with amendments of the Lunacy Laws and Part VI (sections 76-80) with Miscellaneous provisions.

107. Defectives found neglected or abandoned, without visible means of support, or cruelly treated.

108. Under the meaning of the Inebriates Acts 1879-1900.

109. Section 3.1(C) did not use this term but provided that a defective was liable to be dealt with if during any consecutive period of six months in the year immediately prior to the commencement of proceedings under the Act he or she had been in receipt of indoor relief on three or more occasions.

110. If a local authority refused or neglected to deal with a defective where parental consent had been obtained, or refused or neglected to make application for an order where one was required, the Board was empowered to make arrangements to place the defective or petition the Sheriff.

111. The Royal Asylums kept in close touch with each other during the passage of the Bill and had held conferences. They were, in general, satisfied with the results achieved, although the Crichton Royal Institution was not pleased by section 41 of the Act which required it to make provision for adult defectives sent to a certified institution by local authorities in Dumfries, Kirkcudbright and Wigtown (Easterbrook, op.cit., pp. 368-70).

112. First Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1915], PP 1914-16, xxvii, Cd. 7944, pp. xv-xvii.

113. Ibid., pp. xvi-xvii.

114. Ibid., pp. l-lvi.

Chapter 2: Footnotes

1. In the latter part of 1914 the General Board received inquiries from several asylums about the appropriate steps which should be taken in the event of invasion. It referred them to the military authorities (S.R.O.MC8/1 (May 1914-1917), Minute Books of the General Board of Control for Scotland, 18 November 1914 and 6 January 1915).

2. Public feeling may have been whipped up by 'the unworthy and uncharitable propaganda' of some of the press (Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), p. 394).

3. The Edinburgh Royal Asylum received about thirty officers and men in 1915 (One Hundred and Third Annual Report of the Royal Edinburgh Asylum For the Year 1915, p. 14).

4. The Managers had held a special meeting on 19 August at which it had been resolved to offer to maintain and treat twenty-five soldiers or sailors (Easterbrook, op.cit., p. 385).

5. Ibid., p. 394.

6. Ibid., p. 409.

7. When the scheme began, the serviceman was admitted and treated as a pauper while the asylum superintendent sent a statement of his particulars and an application for treatment as a service patient to the Ministry of Pensions and the General Board; it was only on receipt of notification from the Pension Issue Office that he was entitled to be a service patient that the patient was 'de-pauperised'. Under new arrangements introduced in 1918, however, service patients were admitted into hospitals as private patients without passing through a preliminary stage as paupers, and suitable and willing cases were admitted without certification (ibid., p. 408 and p. 419).

8. The cases admitted in Edinburgh were mostly cases of mania and mental deficiency (One Hundred and Third Annual Report of the Royal Edinburgh Asylum For the Year 1915, pp. 14-15. Similarly, most of the sixty-four servicemen treated in the Aberdeen Royal Asylum during the war had not been abroad, and were mostly cases of deficiency or 'dementia' (Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1921, p. 7).

9. Annual Report ... Aberdeen Royal ... 1921, p. 7.

10. Those in the first group were pensionable and were eligible for hospital treatment as service patients for as long as they required it. Those in the second group were non-pensionable, and were eligible for treatment as service patients only during the war and for twelve months afterwards. Servicemen with a history of asylum confinement were not eligible for classification as service patients (Easterbrook, op. cit., pp. 408-9).

11. S.R.O.MC8/1 (May 1914-1917), Minute Books of the General Board of Control for Scotland, 18 November 1916.

12. Easterbrook, op.cit., pp. 393-94. The Crichton Royal received ninety-four Dykebar patients in January 1916.

13. The Edinburgh Royal Asylum received all pauper cases from the City of Edinburgh, new cases from Perth were distributed among Fife, Dundee, Inverness and Stirling, while new cases from Renfrew were accommodated in Perth District Asylum and Greenock Parochial Asylum.

14. Easterbrook, op.cit., pp. 394-95.

15. One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, p. 17 and One Hundred and Third Annual Report of the Royal Edinburgh Asylum For the Year 1915, pp. 13-14.

16. Easterbrook, op.cit., p. 396.

17. The Crichton Royal Institution, for example, submitted claims for exemption on behalf of all the remaining attendants and some tradesmen in 1915, but the Edinburgh Royal Asylum asked for very few exemptions (ibid., p. 396 and One Hundred and Fourth Annual Report of the Royal Edinburgh Asylum For the Year 1916, p. 15).

18. One Hundred and Third Annual Report of the Royal Edinburgh Asylum For the Year 1915, pp. 13-14.

19. 'Female Nurses for Male Insane Patients', The Poor Law and Local Government Magazine, 26 (1916), Part 1, p. 192.

20. Easterbrook, op.cit., p. 389.

21. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1915, p. 28.

22. Easterbrook, op.cit., p. 389.

23. 150 Army orderlies had been assigned to asylums by 1918 (Fifth Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1919], PP 1919, xxv, Cmd. 143, p. vi.

24. Easterbrook, op.cit., passim.

25. Indeed, the Crichton Royal Institution had enough surplus produce to send a weekly hamper of fruit and vegetables to the Navy, and to provide milk for the local Red Cross Hospitals (ibid., p. 395).

26. Fifth Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1919], p. ix.

27. However, the General Board denied that the increased death-rate

(shown in Table 2:4) was attributable to diet, believing that staff shortages and an increased number of patients, which made early detection of disease difficult, were more significant (ibid., pp. ix-x).

28. One Hundred and Third Annual Report of the Royal Edinburgh Asylum For the Year 1915, p. 15.

29. Dr. Robertson, for example, remarked that in view of what had been done for servicemen, doctors would not easily accept the assertion that the adoption of similar measures was impossible for other patients (One Hundred and Fifth Annual Report of the Royal Edinburgh Asylum For the Year 1917, p. 19).

30. Twentieth Annual Report of Govan District Asylum For the Year Ended 14 May 1916, p. 8.

31. One Hundred and Fifth Annual Report of the Royal Edinburgh Asylum For the Year 1917, pp. 20-21, and One Hundred and Sixth Annual Report of the Royal Edinburgh Asylum For the Year 1918, p. 19.

32. Dr. Oswald, Physician-Superintendent of Glasgow Royal Asylum, had been among those who were convinced that all forms of 'nerve instability' were certain to increase (One Hundred and First Annual Report of Glasgow Royal Asylum For the Year 1914, p. 19.

33. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1914, p. 25.

34. One Hundred and Second Annual Report of Glasgow Royal Asylum For the Year 1915, p. 19.

35. The commonest being the belief of some melancholic patients that they were personally responsible for the war (One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, p. 16.

36. As in the case of half a dozen patients admitted to Govan District Asylum in 1916 (Twentieth Annual Report of Govan District Asylum For the Year Ended 14 May 1916, p. 7). A connection between the war and mental breakdown was 'apparent or traceable' in nineteen of the 146 new admissions to the Crichton Royal Institution in 1916 and in approximately 11 per cent of all admissions due to emotional factors during the war years (Easterbrook, op.cit., pp. 400, 419). The war was stated to have been 'an exciting cause' in five female and two male patients admitted to Aberdeen Royal Asylum in 1915 (Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1915, p. 26).

37. One Hundred and Second Annual Report of Glasgow Royal Asylum For the Year 1915, p. 19.

38. One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, p. 12.

39. As in the case of a woman admitted to Aberdeen Royal Asylum in 1917 whose relatives attributed her breakdown to the war but who was actually suffering from advanced general paralysis of the insane (Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1917, p. 12).

40. Dr. Easterbrook summed up the general feeling in his assertion that war claimed its victims from among 'the more unstable elements in the civil population' (Easterbrook, op.cit., p. 419).

41. At the Aberdeen Royal Asylum, for example, there was, after an initial increase in certified admissions in 1915, a fall from 269 in that year to 223 in 1916 and 212 in 1917 (Annual Reports of Aberdeen Royal Asylum For the Years Ended 31 December 1915, p. 26, 31 December 1916, p. 25, and 31 December 1917, p. 8). At the Edinburgh Royal Asylum, admissions initially increased enormously - from 240 in 1914 to 462 in 1915 - because the Asylum received cases which would previously have gone to Bangour, but although it continued to receive all cases from the City of Edinburgh, admissions subsequently decreased to 424 in 1916 and 393 in 1917 (Annual Reports of the Royal Edinburgh Asylum: One Hundred and Second For the Year 1914, p. 10; One Hundred and Third For the Year 1915, p. 11; One Hundred and Fourth For the Year 1916, p.11, and One Hundred and Fifth For the Year 1917, p. 13). At Govan District Asylum, the number of admissions from Govan District fell from 309 in 1913-14 to 254 in 1914-15 and to 219 in 1915-16 (Twentieth Annual Report of Govan District Asylum For the Year Ended 14 May 1916, p. 7.

42. Annual Report of Govan District Asylum ... 1916, p. 7.

43. Easterbrook, op.cit., pp. 400, 419.

44. Table 2:1(B).

45. Table 2:2.

46. Table 2:2.

47. William Graham, M.D., 'War and the Incidence of Insanity', P.L.L.G.M., 27 (1917), Part 1, p. 21. Graham was the Medical-Superintendent of Belfast District Lunatic Asylum.

48. The lunacy statistics continued to include mental defectives who had not been recertified under the 1913 Act.

49. Although there was a decrease of 449 in the number of known lunatics between 1915 and 1916, the real decrease was much less than that as the figure included 317 Training School inmates who had been transferred from the Lunacy Acts to the Mental Deficiency Act (Second Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1916], PP 1916, xiii, Cd. 8313, p. vii).

50. Table 2:4.

51. Table 2:5.

52. One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, pp. 12-13.

53. Easterbrook, op.cit., p. 400.

54. One Hundred and Second Annual Report of Glasgow Royal Asylum For the Year 1915, p. 19, and One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, pp. 12-13.

55. ...Annual Report ... Royal Edinburgh Asylum ... 1914, p. 13.

56. Many asylums reported such a decline. The experience of the Edinburgh Royal Asylum where, in 1917, alcoholic excess was directly responsible for approximately 3 per cent of female admissions, compared to about 9 per cent in the years before the war, was by no means unusual (One Hundred and Fifth Annual Report of the Royal Edinburgh Asylum For the Year 1917, p. 13).

57. Mental deficiency institutions, unlike asylums, were not used as war hospitals, although Stoneyetts Certified Institution only received a last-minute reprieve from being taken over by the Admiralty when Stirling District Asylum was substituted for it (S.R.O.MC8/2 (1918— 21), Minute Books of the General Board of Control for Scotland, 6 March and 3 April 1918).

58. One Hundred and Second Annual Report of the Royal Edinburgh Asylum For the Year 1914, pp. 1-2.

59. First Annual Report of the Scottish Board of Health 1919, PP 1920, xvii, Cmd. 825, p. 35.

60. Table 2:6.

61. S.R.O. MC8/1 (May 1914-1917), Minute Books of the General Board of Control for Scotland, 24 March 1915.

62. Twentieth Annual Report of the Local Government Board for Scotland 1915, PP 1914-16, xxvi, Cd. 8041, p. xii.

63. The contribution from Treasury funds rose from £4,078 in the year ended 15 May 1915 to £17,441 in the following year, £19,963 in the year ended 15 May 1917, and £19,978 in the year ended 15 May 1918 (all figures from the Annual Reports of the General Board of Control for Scotland).

64. Expenditure by local authorities on mental defectives in the year ended 15 May 1915 was £8,339 and (after making allowances for the amount recovered from private sources and from the Treasury contribution) was £4,079 net. In the following year it was £36,001 (£17,412 net), in the year ended 15 May 1917 it was £41,992 (£20,743 net), and in the year ended 15 May 1918 it was £50,929 (£29,221 net) (all figures from the Annual Reports of the General Board of Control for Scotland).

65. Easterbrook, op.cit., p. 393. A few beds were reserved for mental defectives - although none were sent - until the Institution was obliged to accommodate patients transferred from Renfrew District Asylum in Grierson Hall.

66. The licences for Middleton Hall and Grierson Hall thus lapsed (Second Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1916], pp. xxvi-xxvii).

67. It was licensed for the reception of seventy juveniles (Third Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1917], PP 1917-18, xvi, Cd. 8565, p. xxix.

68. Fourth Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1918], PP 1918, xi, Cd. 9068, pp. xxxi-xxxii).

69. Table 2:6. The number of defectives certified and placed under guardianship each year rose from 89 in the period May-December 1914 to 244 in 1915 but then steadily fell to 159 in 1916, 130 in 1917 and 98 in 1918 (all figures from the Annual Reports of the General Board of Control for Scotland).

70. S.R.O.MC8/1 (May 1914-1917), Minute Books of the General Board of Control for Scotland, 28 April 1915.

71. Easterbrook, op.cit., p. 419.

Chapter 3: Footnotes

1. Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), p. 420.

2. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1919, p. 9.

3. Influenza was largely responsible for the increased mortality rate among asylum inmates, which rose from 12.1 per cent in 1917 to 14.6 per cent in 1918 (Fifth Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1919], PP 1919, xxv, Cmd 143, p. vi).

4. Easterbrook, op. cit., p. 425.

5. As the Union informed the Managers of the Edinburgh Royal Asylum in 1919 (One Hundred and Seventh Annual Report of the Royal Edinburgh Asylum For the Year 1919, p. 21).

6. One Hundred and Sixth Annual Report of the Royal Edinburgh Asylum For the Year 1918, p. 17. Dr. Robertson asserted that union activists were salving their guilty consciences by the thought that they were now 'doing their bit' for their fellow-workers.

7. One Hundred and Seventh Annual Report of the Royal Edinburgh Asylum For the Year 1919, p. 1. The majority of staff, however, apparently remained 'loyal to their duties'.

8. Easterbrook, op. cit., pp. 438-39.

9. The Mental Deficiency and Lunacy (Amendment) Act 1919 removed the £20,000 limit imposed by the 1913 Act, abolished the restriction on the rate of interest at which district boards could borrow money, and extended their powers to borrow money for current expenditure.

10. It was, however, a slow process; Bangour Asylum, for example, was a military hospital until December 1921 (H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 (1974), pp. 123-24).

11. These amenities are described in chapters 4 and 5.

12. Again, these questions are explored more thoroughly in subsequent chapters.

13. Easterbrook, op. cit., pp. 519-20.

14. Ministry of Reconstruction, Local Government Committee, Report on Transfer of Functions of Poor Law Authorities in England and Wales (1918), PP 1917-18, xviii, Cd 8917, passim.

15. Sixth Annual Report of the Scottish Board of Health 1924, PP 1924-25, xiii, Cmd 2416, pp. 192-93.

16. Ibid., pp. 192-93.

17. Scottish Board of Health, Consultative Council on Medical and Allied Services, Interim Report, A Scheme of Medical Service for Scotland (1920), PP 1920, xvii, Cmd 1039, passim.

18. John S. Gibson, The Thistle and the Crown: A History of the Scottish Office (1985), p. 71. Sir John was Secretary of State for Scotland 1926-29 and subsequently Chairman of the Committee on Scottish Administration (1936-37). Elliot was Parliamentary Under-Secretary of State for Scotland to Gilmour and Secretary of State for Scotland 1936-38.

19. Scottish Office, Proposals for Reform in Local Government in Scotland and in the Financial Relations Between the Exchequer and Local Authorities (1928), PP 1928, xix, Cmd 3135, paras. 8-14 passim.

20. Tom Johnston M.P., moving the rejection of the Bill, argued that it attacked the democratic foundations of local government, dissipated effective local interest, and would hamper developments in the health service (George Pottinger, The Secretaries of State for Scotland 1926-76 (1979), p. 35).

21. The exceptions being the score of large burghs with over 20,000 inhabitants which were lunacy and mental deficiency authorities but which were not education authorities.

22. The major general health functions having also been concentrated into the hands of the major local authorities.

23. Selkirk's administrative scheme provided for a joint 'Health and Public Assistance Committee' (S.R.O. DD5/841 (1930-47), Local Government (Scotland) Act 1929, Administrative Schemes, Selkirk County [hereinafter cited as Selkirk Scheme]. Altogether, ten local authorities established such joint committees (Seventeenth Annual Report of the General Board of Control for Scotland For the Year 1930, PP 1931-32, xi, Cmd 3976, p. vii).

24. S.R.O. DD5/839 (1930-47), Local Government (Scotland) Act 1929, Administrative Schemes, Aberdeen County [hereinafter cited as Aberdeen Scheme].

25. S.R.O. DD5/840 (1930-47), Local Government (Scotland) Act 1929, Administrative Schemes, Dumbarton County [hereinafter cited as Dumbarton Scheme]. The Board also issued a circular to the new authorities in 1929 urging the establishment of mental health sub-committees (Seventeenth Annual Report of the General Board of Control for Scotland For the Year 1930, p. vii).

26. Aberdeen Scheme.

27. Few records of administrative schemes made under the Act survive, but Selkirk and Dumbarton, for example, did not make specific provision for mental health sub-committees (Selkirk Scheme and Dumbarton Scheme).

28. Second Annual Report of the Department of Health for Scotland 1930, PP 1930-31, xiv, Cmd 3860, pp. 157-58.

29. The General Board, in urging the removal of the mentally disordered from the Poor Law, referred to mental defectives alone (Aberdeen Scheme and Selkirk Scheme). Selkirk County Council provided that the maintenance and treatment of 'mentally deficient persons' was to be dissociated from the Poor Law (Selkirk Scheme), while the Department of Health noted that schemes had provided for the removal from the Poor Law of 'persons mentally deficient' (Second Annual Report of the Department of Health for Scotland 1930, p. 158). None of these sources referred to the removal of lunatics from the Poor Law. It is not clear from these or other sources why this was so.

30. Aberdeen Scheme.

31. Selkirk Scheme.

32. Second Annual Report of the Department of Health for Scotland 1930, p. 158. The scarcity of records again means that no exact figures are available.

33. Gibson, op. cit., p. 71.

34. In particular, it meant that many questions were dealt with both by the Department and (on behalf of the Secretary of State) the Scottish Office, thus causing duplication and delay (Pottinger, op. cit., p. 18).

35. Although in practice it was the General Board which, for example, sanctioned the admission of voluntary patients into asylums.

36. Eighth Annual Report of the Department of Health for Scotland for 1936, PP 1936-37, xi, Cmd 5407, p. 11.

37. D.H.S., Report of the Committee on Scottish Health Services (1936), PP 1935-36, xi, Cmd 5204, Introduction, p. 10.

38. Ibid., para. 695. The differences between doctors who adhered to an organic viewpoint and those who stressed the importance of emotional factors is discussed further in chapter 6.

39. Ibid., para. 695.

40. Ibid., para. 830.

41. Ibid., para. 699.

42. These reactions to the Cathcart Report are in Scottish Office, Report of the Committee on Scottish Administration (1937),

PP 1936-37, xv, Cmd 5563, paras. 65-66 [hereinafter cited as the Gilmour Report].

43. Pottinger, op. cit., p. 32.

44. The Gilmour Report, Part IV, passim.

45. Ibid., Part IV, passim.

46. Significantly, perhaps, the Cathcart Report did not particularise as to which of the Board's functions should be transferred to the Department and which should be transferred to the Sheriff. This may have been a tacit recognition that the separation of the Board's quasi-judicial and administrative functions was not a simple matter.

47. S.R.O. HH101/959 (1945-46), N.H.S., General Policy, Functions of General Board of Control, D.H.S. Memorandum 'The General Board of Control for Scotland', 7 June 1945.

48. Ibid., Minute, 9 December 1937.

49. Quoted in Pottinger, op. cit., p. 76. This view was not universally shared, however; J.J. Davidson M.P. described the legislation as a 'piece of bunkum' (quoted in ibid., p. 76).

50. Ibid., p. 20. One of these was Tom Johnston, who felt that the Gilmour Committee's terms of reference had been too restrictive (ibid., p. 76).

51. Ibid., p. 19.

52. Gibson, op. cit., p. 88.

53. The Russell Committee's subsequent re-activation, and its report, are discussed in Part III.

Chapter 4: Footnotes

1. Gillian Sutherland, Ability, Merit and Measurement: Mental Testing and English Education 1880-1940 (1984), pp. 53-54.

2. Stern obtained the I.Q. by dividing the mental age by the chronological age, multiplying the result by one hundred and rounding it off to eliminate fractions (ibid., p. 54).

3. Gertrude Keir, 'A History of Child Guidance', Symposium on Psychologists and Psychiatrists in the Child Guidance Service, British Journal of Educational Psychology, 22, Part 1 (February 1952), p. 21.

4. L.S. Hearnshaw, Cyril Burt, Psychologist (1979), p. 17.

5. 'James Drever' in Carl Murchison (ed.), A History of Psychology in Autobiography Volume II (1932), pp. 24-25. The Lectureship and the Department of Psychology as a whole were named after George Combe, a phrenologist and educationalist whose estate provided a grant for their establishment.

6. Ibid., pp. 23-26.

7. The B.Ed. course, which was open to graduates who were trained teachers, began in Edinburgh and Glasgow in 1917 and in Aberdeen a year later (ibid., pp. 27-28).

8. Marion Blythman, 'The Training of Teachers for Special Education in Scotland', in W.B. Dockrell, W.R. Dunn and A. Milne (eds.), Special Education in Scotland (1978), pp. 37-41 and Catherine M. McCallum, 'Child Guidance in Scotland', Symposium on Psychologists and Psychiatrists in the Child Guidance Service, B.J.E.P., 22, Part 2 (June 1952), p. 8.

9. Sutherland, op. cit., pp. 129-32. The tests referred to were the Moray House Tests of Intelligence, Arithmetic and English.

10. Edinburgh Town Council Education Committee Handbook (1934), pp. 83-84 [hereinafter cited as Education Handbook].

11. N.L.S.Acc. 7170, Scottish Association for Mental Health [hereinafter cited as S.A.M.H. Papers], Box 1, File 3, Scottish Child Guidance Council, Minutes,Reports and Papers, October 1934-November 1937 [hereinafter cited as S.C.G.C. 1934-37]. The statistics came from a questionnaire sent to child guidance clinics, psychological, psychiatric and educational clinics, L.E.A.s, schools and other bodies, the returns of which were included in a report of January 1937.

12. The S.C.R.E. was founded in 1930; Godfrey Thomson was one of its key figures (Sutherland, op. cit., p. 142). Over 87,000 children were group tested in its 1932 survey, and 1,000 of them were also individually tested by the Binet Scale (The Scottish Council for Research in Education, The Intelligence of Scottish Children (1933), passim).

13. S.R.O. ED28/230 (1932), Education and Care of Mentally and Physically Defective Children, Ascertainment and Provision Before and After the Age of Sixteen, Drafting and Issue of Circular [hereinafter cited as Education and Care 1932].

14. S.R.O. ED28/228 (1938), Departmental Committee on the Scottish Lunacy and Mental Deficiency Laws, S.E.D. Memorandum on the Education and Care of Mentally Defective Children [hereinafter cited as S.E.D. Memorandum 1938].

15. D.H.S., Report of the Committee on the Scottish Health Services (1936), PP 1935-36, xi, Cmd 5204, para. 163 [hereinafter cited as the Cathcart Report].

16. The S.E.D. acknowledged that some doctors involved in ascertainment had no special knowledge or experience of mental deficiency, but felt that in the 1930s the situation was improving (Education and Care 1932).

17. Ibid., and S.R.O. ED28/231 (1936-37), Education and Care of Mentally and Physically Defective Children, Ascertainment and Provision Before and After the Age of Sixteen, Drafting and Issue of Circular [hereinafter cited as Education and Care 1936-37].

18. Education and Care 1936-37.

19. Jas. B. Frizell, the City Education Officer in Edinburgh, in 1937 contended that tests were instrumental in overcoming this reluctance (ibid.).

20. The widening of the definition of mental defect was contained in section 1.

21. Dr. McAlister's suggestion that an annexe at Gogarburn Institution should be provided never materialised; the child welfare service in Edinburgh admitted a few defective under-fives to residential nurseries for short periods during the summer, and a few of the more 'amenable' were admitted to the service's day nurseries (H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 (1974), p. 128.

22. It is difficult to provide systematic information about variations in ascertainment, but the unevenness was acknowledged by the S.E.D. in 1931 (in S.R.O. ED28/229 (1931), Lunacy (Scotland) Acts and Mental Deficiency and Lunacy (Scotland) Act 1913, Suggested Amendments [hereinafter cited as Suggested Amendments 1931], and in Education and Care 1932 and Education and Care 1936-37. It was also noted in the Cathcart Report, para. 163.

23. City and Royal Burgh of Edinburgh, Third Annual Progress Report of the Education Committee and Annual Report on the Work of Schools for the Session 1931-32, p. 13.

24. S.E.D. Memorandum 1938. The 199 comprised 175 women and 24 men.

25. The S.E.D.'s statistics in the years immediately after the war did not distinguish between mentally and physically defective pupils but the 1919 figure is given in S.E.D., Report of the Committee of Council on Education in Scotland For the Year 1929-30, PP 1929-30, xiii, Cmd 3565, pp. 28-29. The number of defectives in special schools, and the types of provision available, in 1938, are given in S.E.D., Report of the Committee of Council on Education in Scotland For the Year 1938, PP 1938-39, x, Cmd 6007, p. 40 [hereinafter cited as Education Report 1938].

26. The new institutions provided in the inter-war period included St. Joseph's R.C. institution in Rosewell, Dunlop House near Kilmarnock (opened in 1933 by Ayrshire County Council and Ayr and Kilmarnock Town Councils), Birkwood Certified Institution, Lesmahagow (provided by Lanark County Council and the Town Councils of Airdrie, Coatbridge, Hamilton, Motherwell and Wishaw, and Rutherglen) and Broadfield Certified Institution, Port Glasgow (provided by Paisley Town Council) (Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, PP 1938-39, xii, Cmd 5970, passim). Gogarburn Institution (provided by Edinburgh Town Council) was first opened in 1924 and was considerably extended in the following years; by 1939 it accommodated over 500 adult and juvenile patients (Tait, op. cit., pp. 128-30).

27. This estimate was provided by W.W. McKechie, an Inspector of Schools (Notes of the Month, 'Mental Deficiency and Social Problems', The Poor Law and Local Government Magazine, 32 (1922), Part 1, p. 113).

28. Suggested Amendments 1931.

29. Education and Care 1936-37.

30. One of the eleven boarding schools for the physically defective which were established in 1938 did accept mental defectives, but only on a day basis (Education Report 1938, p. 40).

31. The exceptions were large burghs. There, the town council (as the local authority) was responsible for ineducables but (not being the education authority) it was not responsible for educables; they were the responsibility of the county council (the L.E.A.).

32. The Slateford Occupation Centre for ineducables, which had been conducted by a voluntary organisation, was from 1932 controlled by the Education Committee (Edinburgh Corporation Education Committee, Annual Report on the Work of Schools for the Session 1930-31, p. 108).

33. For the reason described in note 31 above.

34. No exact figures are available but in the early 1930s the S.E.D. acknowledged that 'many' low-grade cases were enrolled and retained in special schools and classes (Education and Care 1932).

35. Ibid.

36. These centres are described later in the chapter.

37. As described in note 32 above.

38. Section 7(2)(i) of the English Mental Deficiency Act 1927 enabled English local authorities to provide training centres for ineducables.

39. The General Board in 1931 urged that the 1913 Act should be amended so as to empower, or even require, local authorities to establish occupation centres (Suggested Amendments 1931). The S.E.D. made the same suggestion in its 1938 memorandum to the Russell Committee (S.E.D. Memorandum 1938).

40. Suggested Amendments 1931. The Board's contention that the position of ineducables had actually deteriorated since 1913 was based on the fact that before the Act it was possible for low-grade children to attend an ordinary or special school if one was available.

41. As the S.E.D. admitted (Education and Care 1932).

42. Suggested Amendments 1931.

43. Once again, the exceptions were large burghs, where intimation from the county council to the town council was required when a defective reached school-leaving age.

44. Both the Board and the Department in the 1930s urged that after-care should be extended to defectives leaving ordinary schools but their representations were unsuccessful (Suggested Amendments 1931 and S.E.D. Memorandum 1938).

45. Education and Care 1932 and 1936-37.

46. It is difficult to trace the foundation and earliest years of the Association since the records before 1926 are scanty. However, the establishment of S.A.C.C. is described in a retrospective note included in a much later report (S.A.M.H. Papers, Box 3, File 1, Minutes etc., 1968-72) and the General Board's support and the Association's early agenda are described in Notes of the Month 'After-Care of Defective Children: Proposed Scottish Society', P.L.L.G.M. 32 (1922), Part 1, pp. 218-19 [hereinafter cited as After-Care Article].

47. The Association's constitution and aims are described in After-Care Article and in S.A.M.H. Papers, Box 1, File 1, Scottish Association for Mental Welfare, Minutes and Other Related Papers, 27 November 1926-28 May 1938 [hereinafter cited as Minutes 1926-38].

48. The only surviving records of local groups in the inter-war period are those of Hamilton and Dumbarton and Vale of Leven. These show that representatives of parish and town councils,

school management committees, the Co-operative Society and the S.S.P.C.C. were involved in the groups in the 1920s and 1930s. Both groups also had a considerable number of volunteers (generally somewhere between twenty and thirty) engaged in domiciliary visitation (S.A.M.H. Papers, Box 4, File 10, Dumbarton and Vale of Leven Care Committee, Annual Reports 1930-32, 1934-38 [hereinafter cited as Dumbarton Group], and Box 6, File 7, Hamilton Local Care Committee for Mental Welfare 1928-38 [hereinafter cited as Hamilton Group]. The number of visitors in some other groups in 1933 was provided by the General Board; fifty in Clydebank, eight in Dunfermline and seventy-two in Paisley (Twentieth Annual Report of the General Board of Control for Scotland For the Year 1933, PP 1933-34, xiii, Cmd 4712, pp. xxvii-xxxiii).

49. Twentieth Annual Report of the General Board of Control for Scotland For the Year 1933, pp. xxvii-xxxiii.

50. S.A.M.W.'s finances are detailed in S.A.M.H. Papers, Volume 2 (1921-28), Volume 3 (1927-37) and Volume 4 (1937-42) of the General Income and Expenditure Account Books of the Association, and Minutes 1926-38.

51. The Dumbarton and Vale of Leven group's grant from S.A.M.W., for example, was £10 in 1930, £30 in 1931, £35 in 1932 (1933 missing), £15 in each of the years 1934-37 and (apparently) nothing in 1938 (S.A.M.H. Papers, Dumbarton Group). Hamilton's grants from the parent association also showed fluctuations (ibid., Hamilton Group).

52. At least some of the proceeds of the force's charity football match were regularly donated to the group (ibid., Dumbarton Group).

53. Ibid., Dumbarton Group and Hamilton Group.

54. The group did conduct an employment centre for adolescent and adult male defectives, but its ambition to open centres for females and ineducable juveniles did not appear to be realised, largely because of lack of funds (ibid., Dumbarton Group).

55. The establishment of local groups in the Aberdeen area remained one of the Association's aims at the end of the 1930s (ibid., Box 1, File 5, Scottish Association for Mental Hygiene, Minutes and Other Organisational Papers, 18 July 1938-9 June 1939 [hereinafter cited as Minutes 1938-39].

56. Ibid., Box 1, File 2, Reports of the Mental Hygiene Sub-Committee (later Committee) of the Association, 2 November 1928-2 April 1937 [hereinafter cited as Hygiene 1928-37], and Minutes 1926-38. The Association's role in conducting clinics is described later in this chapter and in chapter 5.

57. S.A.M.H. Papers, Hygiene 1928-37 and Minutes 1926-38.

58. Ibid., Box 1, File 4, Papers Concerning the Amalgamation of the S.A.M.W. and the Child Guidance Council, 14 January 1937-28 May 1938, and Minutes 1926-38 and 1938-39.

59. Ibid., Minutes 1938-39.

60. A post-amalgamation survey found 119 members interested in mental health, 135 in child guidance and 136 in mental deficiency. 161 members had not replied (ibid., Minutes 1938-39).

61. Ibid., Minutes 1938-39.

62. It is difficult to follow the growth of the Association's membership but, as note 60 above indicates, it had a substantial number of members in the late 1930s. Those active in the Association in the inter-war years included many psychiatrists; among them were Professor Robertson, Superintendent of Edinburgh Royal Mental Hospital; Dr. (later Professor) Henderson, Superintendent of Glasgow Royal Mental Hospital (and subsequently of Edinburgh Royal); Dr. Chambers, Superintendent of the Murray Royal Asylum; and Dr. Dods Brown, Superintendent of Aberdeen Royal Mental Hospital. The psychologists and educationalists who were involved in the Association's work included Godfrey Thomson, James Drever Snr., Professor of Psychology at Edinburgh University in the 1930s; David Kennedy Fraser; and two of the pioneers of child guidance, Rex Knight and William Boyd (S.A.M.H. Papers, passim).

63. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1920, pp. 8-9.

64. One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 22.

65. However, while the earliest English clinics are generally considered to be those opened by Cyril Burt, by the Tavistock Clinic and by the Jewish Health Organisation in London in the 1920s, Keir and McKnight contend that Francis Galton's 'anthropometric laboratory', opened in London in 1884, can be regarded as the first child guidance clinic (Keir, op. cit., p. 8 and R.G. McKnight, 'The Development of Child Guidance Services' in Dockrell et al., op. cit., p. 97).

66. Professor Drever's clinic in the early 1930s moved to new premises purchased by the Managers of the Edinburgh Royal Mental Hospital (One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 2.

67. McCallum, op. cit., p. 80.

68. Ibid., p. 80.

69. Ian Swanson, Review of Freedom to Grow: Sister Marie Hilda's Vision of Child Guidance, by Sister Jude , Scottish Educational Review 14, No. 1 (May 1984), pp. 67-68.

70. The Perth clinic was established in 1932 and was one of the clinics with which S.A.M.W. was involved. Later on in the decade it affiliated to the Scottish Child Guidance Council (Harry Stalker, 'The Next Fifty Years 1927-1977', in Murray Royal Hospital Perth 1827-1977 (n.d.), p. 27).

71. Keir contends that the S.C.G.C. ceased to exist in 1935 (Keir, op. cit., p. 22), but the Council's records show that it was still active in 1937 (S.A.M.H. Papers, S.C.G.C. 1934-37). It finally ceased to exist when it amalgamated with S.A.M.W. in 1938.

72. The Cathcart Report, para. 703.

73. The Corporation of Glasgow Education Department, Report on Child Guidance Service Session 1956-57, pp. 6-7. The cost of establishing the first clinic was approximately £100: 245 cases made 1,204 visits to the clinic during 1937.

74. The voluntary organisation concerned was the local branch of the 'New Education Fellowship' (McCallum, op. cit., p. 82).

75. The S.C.G.C. reported in 1937 that individual intelligence tests and educational attainment tests were widely used in almost all clinics. Group intelligence tests had little application in child guidance, but a variety of temperament and character tests - among them the well-known Rorschach Inkblots Test - were being tried out 'tentatively' (S.A.M.H. Papers, S.C.G.C. 1934-37).

76. McCallum, op. cit., p. 80.

77. In Edinburgh, for example, suspected psychiatric cases were referred to the Corporation's Mental Hygiene Clinic (Education Handbook, p. 103).

78. The first training course for psychiatric social work in Britain was the Mental Health Course established at the London School of Economics in 1929; it was the sole course in the inter-war period (M.O.H./D.H.S., Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services (1959), para. 222.

79. Keir, op. cit., p. 22.

80. Tenth Annual Report of the Department of Health for Scotland for 1938, PP 1938-39, xi, Cmd 5969, p. 92.

Chapter 5: Footnotes

1. There was frequently a long delay between the onset of mental illness and asylum treatment; the example of Ayr District Asylum - where 40 per cent of the male patients and 50 per cent of the female patients who entered the institution in 1918 had shown mental symptoms for over a year before admission - was not unusual (Notes of the Month, 'Admissions to Mental Hospitals', The Poor Law and Local Government Magazine 28 (1918), Part 1, pp. 207-208). The evidence which supported the contention that such a delay quite spoiled the chance of recovery , and that early treatment had the opposite effect, was suggestive rather than conclusive, but the fact that, for example, thirty-six of the seventy-eight patients discharged recovered from the Aberdeen Royal Asylum in 1919 had been sent into the institution within three months of the onset of the illness was cited as evidence of the benefits of early treatment (Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1919, p. 8).

2. At the Crichton Royal there were some years in which the recovery rate for certified patients was actually higher than that of voluntary patients; in 1926, for example, the recovery rate of certified patients was 36.5 per cent while that of voluntaries was 32.5 per cent. However, there were also many years in which the recovery rate for voluntaries was much higher than that for certified patients; in 1929, for example, the figures were 43.7 and 23.1 respectively. The recovery rate of voluntary patients in the period 1908-36 was (at 39.9 per cent) 5 per cent higher than that of certified patients (34.9 per cent) (Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), passim).

3. For example, Professor Robertson noted in 1927 that four-fifths of voluntaries left the Edinburgh Royal within twelve months of admission. Underlying this impressive result, however, were the following discharge figures: 1927, voluntaries recovered 41, unrecovered/relieved 78; certified recovered 20, unrecovered/relieved 39. 1928, voluntaries recovered 32, unrecovered/relieved 80; certified recovered 25, unrecovered/relieved 25. 1929, voluntaries recovered 30, unrecovered/relieved 64; certified recovered 19, unrecovered/relieved 25 * (Annual Reports of the Royal Edinburgh Mental Hospital/Hospital for Mental and Nervous Disorders, 1927-29, passim).

4. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1919, p. 8.

5. One Hundred and Eleventh Annual Report of the Royal Edinburgh Mental Hospital For the Year 1923, p. 9.

6. Professor Robertson, for example, drew an analogy between the judicial procedure involved in committal and Samuel Butler's fictional account of a man who was put on trial for having consumption (One Hundred and Ninth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1921, p. 17).

3 * These figures relate to a total number of patients under treatment during 1927 of 294 voluntary and 812 certified, during 1928 of 277 voluntary and 795 certified, and during 1929 of 281 voluntary and 772 certified.

7. Fifth Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1919], xxv, Cmd 143, p. xii and Fifteenth Annual Report of the General Board of Control for Scotland For the Year 1928, PP 1929-30, xv, Cmd 3413, p. xvii.

8. 204 of the 344 patients admitted to the Institution in 1928 were voluntaries; these 204, all private patients, formed 77 per cent of the 264 private admissions (Easterbrook, op. cit., p. 509).

9. 114 voluntary patients and 98 certified patients were admitted during 1928 (One Hundred and Sixteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1928, Table II, p. 20 and Table III, p. 21).

10. One Hundred and Twelfth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1924, p. 13.

11. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1919, p. 8.

12. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1924, pp. 8-9.

13. At the Crichton Royal Institution, for example, only seventeen of the 2,257 patients who entered on a voluntary basis between 1908 and 1930 were later certified (Easterbrook, op. cit., p. 528). Similarly, it was reported from Glasgow Royal Mental Hospital that the certification of a voluntary patient was a very exceptional event; when it was deemed necessary, the desire to keep the voluntary principle intact meant that relatives had to remove the patient so that the necessary formalities took place outside the institution (One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 18).

14. Since the General Board already examined copies of all admission papers it would, Professor Robertson remarked, be a simple matter to transfer to that body the duty of actually signing them. He also pointed out that when the Sheriff's order expired after three years, the patient's continued detention was authorised by a certificate granted by the asylum superintendent, so one fails to see the necessity for the intervention of the Sheriff in the first instance' (One Hundred and Nineteenth Annual Report, For the Year 1931, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 20).

15. Ibid., p. 20.

16. The English certified patient's freedom to look after his or her own business affairs was, as Dr. Easterbrook noted, 'frequently reduced to vanishing point, the fact of certification ... debarring the individual from such liberty of action' (Easterbrook, op. cit., p. 528). There was similar provision under Scots law: one of the General Board's duties was to initiate the process by which a judicial factor was appointed to manage the estate of a patient who was believed to be mentally unfit to do so. But in Scotland certification was not regarded as a priori evidence of

the patient's incapacity to manage his or her own affairs. It was for this reason that Dr. Easterbrook felt that the Scottish mental patient was not such an 'underdog' as his English equivalent (Easterbrook, op. cit., p. 529).

17. Dr. Easterbrook, for example, in 1921 urged that the definition of those entitled to voluntary treatment should confine itself to the patient's wish to enter an asylum, and should omit the existing 'obfuscating' qualification (ibid., p. 458), and Professor Robertson also felt that the nature and pitch of the patient's disorder was not nearly as significant as the desire to submit to treatment (One Hundred and Ninth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1921, p. 19).

18. It declared that patients could only be admitted as voluntaries if it was not legal to grant certificates (D.H.S., Report of the Committee on Scottish Health Services (1936), PP 1935-36, xi, Cmd 5204, para. 698) [hereinafter cited as the Cathcart Report].

19. One Hundred and Thirteenth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1925, p. 6. Section 59 was the one which - as already described in chapter 1, and referred to earlier in this chapter - eliminated the delay in voluntary admissions by providing that a superintendent could admit the voluntary patient immediately upon application. Since it stated that in all other respects section 15 of the 1866 Act remained 'in full force and effect', it does not seem to justify Professor Robertson's claim.

20. Some of the patients admitted as voluntaries to the Crichton Royal Institution in 1926 were, Dr. Easterbrook admitted, actually certifiable (Easterbrook, op. cit., p. 493).

21. Annual Reports of Aberdeen Royal Asylum For the Year Ended 31 December 1924, p. 9 and For the Year Ended 31 December 1927, p. 9.

22. The Board consistently urged individual asylums to encourage local authorities to admit paupers as voluntaries, and it included a general incitement to that effect in its report for 1920 (Seventh Annual Report of the General Board of Control for Scotland [for the year ended 1 January 1921], PP 1921, xv, Cmd 1396, p. xli).

23. In 1924 the Managers of the Edinburgh Royal Hospital made an offer to Edinburgh Parish Council to admit into the institution up to twenty pauper voluntaries, and arranged to contribute from the institution's charitable funds the difference between the lowest rate of board at the Royal and the amount (less the Government grant) which the Council paid for the maintenance of its certified pauper patients in the Edinburgh District Asylum. The cost to the local authority of these pauper voluntaries would therefore not exceed that for certified patients receiving the full benefit of the Government grant (One Hundred and Twelfth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1924, pp. 2 and 14).

24. One Hundred and Sixteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1928, p. 21.

25. Ibid., p. 21.

26. Annual Report of Aberdeen Royal Asylum For the Year Ended 31 December 1922, p. 7.

27. Easterbrook, op. cit., p. 481.

28. Ibid., p. 457.

29. There was, however, no hard and fast rule; the term 'pauper' continued to be used (by the General Board and others) after 1929, and the term 'rate-aided' had been used before 1929. In this context, and in subsequent chapters, the term rate-aided is preferred.

30. Report of the Royal Commission on Lunacy and Mental Disorder (1926), PP 1926, xiii, Cmd 2700, passim [hereinafter cited as Lunacy Commission].

31. One Hundred and Fourteenth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1926, p. 15.

32. The Act's temporary patient provisions were contained in section 5.

33. Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1930, pp. 12-13.

34. Easterbrook, op. cit., p. 528. Dr. Easterbrook also referred to an (unattributed) description of the 1930 Act as 'the Magna Charta of the mental invalid' (ibid., p. 528).

35. C.f. ibid., p. 529 and One Hundred and Nineteenth Annual Report, For the Year 1931, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 22-23.

36. Dr. Dods Brown felt that it was 'not too much ... to expect that before long somewhat similar provisions ... will be available for Scotland' (Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1930, p. 14), and Professor Robertson also felt that a Mental Treatment Act for Scotland was impending (One Hundred and Nineteenth Annual Report,For the Year 1931, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 15).

37. However, some Scottish witnesses, including H. Arthur Rose and H.C. Marr of the General Board, and Professor Robertson, were heard (Lunacy Commission, Appendix A, pp. 178-82).

38. Easterbrook, op. cit., p. 560.

39. Of the 3,493 admissions in 1938, 1,109 were voluntary and 2,384 were certified (Annual Report of the General Board of Control for Scotland For the Year 1954, PP 1955-56, xxii, Cmd 9552, p. 6).

40. 126 of the 1,084 patients in Bangour on 1 January 1939 were voluntary, and all but two of the voluntaries were rate-aided (Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, PP 1938-39, xii, Cmd 5970, Appendix, Table V, pp. 9-10).

41. Ibid., Appendix, Table V, pp. 9-10.

42. These changes, however, were complex. The Edinburgh Royal had already dropped the term 'Asylum' from its reports by 1927, but it did not officially become a 'Hospital' until December of that year. Then, the new name of the Corporation became the Royal Edinburgh Hospital for Mental and Nervous Disorders, and that of the Institution became the Royal Edinburgh Hospital for Mental Disorders (One Hundred and Fifteenth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1927, p. 1). The Aberdeen Royal Asylum formally became the Aberdeen Royal Mental Hospital in June 1933 (Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1933, passim) but the designation 'mental hospital' had been used in the Annual Reports since 1925. The Glasgow Royal Asylum became the Glasgow Royal Mental Hospital in 1931 (One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, pp. 14-15) but it had, unofficially, been a mental hospital since 1908. All other asylums continued to have the statutory designation of 'asylum' until after World War Two.

43. Easterbrook, op. cit., p. 501.

44. Harry Stalker, 'The Next Fifty Years 1927-1977' in Murray Royal Hospital Perth 1827-1977 (n.d.), p. 26.

45. One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 2. 186 patients were treated in the nursing homes during the year.

46. Stalker, op. cit., p. 26. The unusual name of the nursing home derived from the property upon which it was built, and was probably of biblical origin.

47. Wellwood, a converted mansion house, was opened with accommodation for twenty patients (Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1931, p. 14).

48. This nursing home - Darleith House - had accommodation for approximately twenty patients (One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 23).

49. D.H.S., Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws (1946), PP 1945-46, xiii, Cmd 6834, paras. 298-300.

50. One Hundred and Sixteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1928, p. 7.

51. It was reported in 1930 that about one-third of the treatment given at Jordanburn was of 'a charitable nature'. In this respect the Hospital differed from similar English institutions - like London's Woodside Nerve Hospital - which were reserved for paying patients (One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, pp. 11-12).

52. There were, in 1936, 270 admissions to Jordanburn and 271 admissions to the Mental Hospital (One Hundred and Twenty-Fourth Annual Report, For the Year 1936, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 7-9).

53. One Hundred and Eleventh Annual Report of the Royal Edinburgh Mental Hospital For the Year 1923, p. 10.

54. About 180 patients visited the clinic during its first year, and many of them attended on a regular basis (One Hundred and Fourteenth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1926, p. 10).

55. The Jordanburn clinic was held daily: 246 patients attended it during its first year (One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 2).

56. H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974, p. 122. The Dispensary Clinic was particularly concerned with the after-care of ex-mental patients, and with the rehabilitation of patients liberated on probation, but it also treated neurotic patients.

57. The Scottish Association for Mental Welfare was closely involved in the establishment and running of the clinics in Paisley, Dundee and Greenock (N.L.S. Acc. 7170, Scottish Association for Mental Health, Box 1, File 2, Reports of the Mental Hygiene Sub-Committee (later Committee) of the Association, 2 November 1928-2 April 1937). It was also actively concerned with the clinic at the Perth Royal Infirmary, which opened in 1932, and Miss Butters of the Association assisted Dr. Chambers with the clinic's work (Stalker, op. cit., p. 27).

58. Some, in fact, were primarily concerned with young patients; the Perth Royal Infirmary Clinic's affiliation with the Scottish Child Guidance Council was described in the last chapter.

59. One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 18. Social workers were also attached to Dr. McAlister's Dispensary Clinic (Tait, op. cit., p. 122), and to Glasgow's Western Infirmary Clinic (One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 21).

60. It appeared that approximately one-fifth of the patients who attended Jordanburn Clinic subsequently received residential treatment in the Nerve Hospital (One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 11.

61. The Committee felt that the association between mental and physical disorders 'points clearly to the wisdom of providing the necessary clinic provision at the general hospitals' (The Cathcart Report, para. 701).

62. One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 21 and One Hundred and Eighteenth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1930, p. 20.

63. Easterbrook, op. cit., p. 586.

64. One Hundred and Twentieth Annual Report, For the Year 1932, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 12.

65. One Hundred and Fifteenth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1927, p. 12.

66. Of the 19,943 patients in Scottish asylums on 31 December 1938 1,480 were voluntary and 18,463 were certified (Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, Appendix, Table V, pp. 9-10).

67. The Cathcart Report, para. 694.

Chapter 6: Footnotes

1. Chapter 1.

2. Butler argues the opposite; that the treatment of shell-shocked soldiers 'provided evidence against the eugenic theories', since war heroes could not easily be dismissed as characters with weak constitutions (Tom Butler, Mental Health, Social Policy and the Law (1985), p. 79). But, as has been described in chapter 2, many of the mentally disordered servicemen in World War I were not war heroes, but were frequently sufferers from 'ordinary' mental illness, or even mental deficiency, who had never been abroad. War, in many cases, did not cause mental disorder but revealed its extent, and strengthened the case for measures to deal with it.

3. John Keay, 'The War and the Burden of Insanity', The Poor Law and Local Government Magazine 29 (1919), Part 1, p. 120 [hereinafter cited as Insanity and War].

4. Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), p. 597. The author was Physician-Superintendent of the Crichton Royal Institution, 1908-36.

5. In Dr. Easterbook's phrase, heredity acted as a 'locus minoris resistentiae' or 'point of least resistance' (ibid., pp. 594-95).

6. Department of Health for Scotland, Report of the Committee on Scottish Health Services (1936), PP 1935-36, xi, Cmd 5204, para. 255 [hereinafter cited as The Cathcart Report].

7. One Hundred and Twentieth Annual Report, For the Year 1932, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 13. D.K. Henderson, previously Superintendent of the Glasgow Royal Mental Hospital, became Superintendent of the Edinburgh Royal Hospital and Professor of Psychiatry at Edinburgh University, in succession to George Robertson, in 1932.

8. C.P. Blacker, Voluntary Sterilization (1934), p. 52.

9. Notes of the Month, 'Training of Mentally Defective Children', PLLGM 36 (1926), Part 1, p. 358.

10. Notes of the Month, 'Mental Deficiency and Social Problems', PLLGM 32 (1922), Part 1, p. 113. McKechnie was an Inspector of Schools and later became Senior Assistant Secretary of the Scottish Education Department.

11. The Cathcart Report, para. 261. The Committee heard evidence which put the proportion of mental deficiency which was hereditary at anything between 5-80 per cent (ibid., para. 262).

12. Its members included F.A.E. Crew, Professor of Animal Genetics at Edinburgh University, who espoused eugenist views (The Cathcart Report, para. 267), and Shepherd Dawson, a psychologist

with close connections with eugenics (Greta Jones, Social Hygiene in Twentieth Century Britain (1986), p. 81). The Chairman, E.P. Cathcart, Professor of Physiology at Glasgow University, had himself signed a petition to the Ministry of Health in support of sterilisation (ibid., p. 100).

13. Keay, Insanity and War, p. 127.

14. Blacker, op. cit., p. 110.

15. Notes of the Quarter, Eugenics Review 23, No. 3 (October 1931), p. 199.

16. Notes of the Month, 'Mental Deficiency - Address by Bangour Medical Superintendent', PLLGM 35 (1925), Part 1, p. 124 [hereinafter cited as Mental Deficiency Address].

17. Blacker, op. cit., pp. 71-73.

18. Mental Deficiency Address, p. 124.

19. Thomson found a negative correlation between intelligence and family size which, given the theory of differential fertility, appeared to hold serious implications for the nation's intelligence. (H.E.G. Shuttleworth and Godfrey H. Thomson, 'The Correlation between Intelligence and Size of Family', British Journal of Psychology 17, No. 2 (October 1925), pp. 81-92.

20. The Committee published the findings of Dr. Lewis, who ascertained a mean incidence of 8.57 mental defectives per thousand in England and Wales, almost twice as great as the 4.6 per thousand discovered by the Royal Commission on the Feeble-Minded in 1908. (Board of Education and Board of Control, Report of the Mental Deficiency Committee (1929), Part IV, Report on an Investigation into the incidence of Mental Deficiency in six areas, 1925-27, by E.O. Lewis, p. 54).

21. The Scottish Council for Research in Education, The Intelligence of Scottish Children (1933), pp. 4-5.

22. The Hon. Lady Whitehead, 'Feeble Minds - A Growing Danger', PLLGM 32 (1922), Part 1, p. 266.

23. Notes of the Month, 'Training of Mentally Defective Children', PLLGM 36 (1926), Part 1, p. 357 and Notes of the Month, 'Mental Deficiency and Social Problems', PLLGM 32 (1922), Part 1, pp. 113-14.

24. Blacker, op. cit., p. 71.

25. Ibid., p. 13.

26. Mental Deficiency Address, p. 124.

27. Keay, Insanity and War, pp. 154-56.

28. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 13.

29. Ibid., p. 14.

30. Ibid., p. 14.

31. G.R. Searle, 'Eugenics and Class', in Charles Webster (ed.), Biology, Medicine and Society 1840-1940 (1981), p. 227.

32. Blacker, op. cit., pp. 13 and 19.

33. N.L.S. Acc. 7170, Scottish Association for Mental Health, Box 1, File 1, Scottish Association for Mental Welfare, Minutes and Other Related Papers, 27 November 1926-28 May 1938, 'The S.A.M.W., Points of Interest from the Ninth Annual Conference held on Friday 22 May 1931'.

34. Ibid., loose page headed 'Educational Institute of Scotland' [1938?], Report on S.A.M.W., Sub-Committee on Mental Hygiene.

35. Report of the Departmental Committee on Sterilization (1934), PP 1933-34, xv, Cmd 4485, paras. 71-74.

36. Ibid., para. 103.

37. Ibid., paras. 71-74. It also recommended that sterilisation be legalised for those suffering from a number of physical conditions.

38. The Committee recommended that if the patient was capable of giving consent, he should sign a declaration of willingness to be sterilised, and that this should be accompanied by two medical recommendations, which must include a statement that the effect of the operation had been explained to the patient and that, in the medical practitioners' opinion, he was capable of understanding it. If the doctors were not satisfied that the patient was capable of real consent, then that of his parent must be obtained (ibid., paras. 79-84 and 89).

39. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 13-14.

40. Searle asserts that the coolness of the B.M.A. was a major consideration when the Minister of Health was deciding the position that the Government should take on the issue. (Searle, 'Eugenics and Class', in Webster, op. cit., p. 226.)

41. The Encyclical on Christian Marriage, issued in December 1930, condemned sterilisation as a pernicious practice advocated by those who had lost sight of the fact that 'the family is more sacred than the State'. (Quoted in Blacker, op. cit., p. 35.)

42. Searle, 'Eugenics and Politics in Britain in the 1930s', Annals of Science 36, No. 2 (March 1979), p. 168 [hereinafter cited as Eugenics and Politics]. Neville Chamberlain was among those sympathetic to a policy of sterilisation (Jones, op. cit., pp. 90-91).

43. Searle, Eugenics and Politics, p. 159.

44. The German Sterilisation Act, which came into operation on 1 January 1934, legalised both voluntary and compulsory sterilisation for those suffering from nine 'hereditary' mental and physical disorders (Blacker, op. cit., pp. 87-88).

45. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 13.

46. Searle, 'Eugenics and Politics' (1979), p. 165. Although the German Act appeared to restrict sterilisation to sufferers from specific morbid conditions, it was alleged (J.B.S. Haldane, Daily Herald, 29 November 1933) that it was compulsorily applied to 'criminals' who had been imprisoned because of their hostility to the Nazi regime, and who were judged racially or politically undesirable.

47. Searle, Eugenics and Politics, p. 160. This guilt may not have been entirely misplaced. While there is little evidence of ideological infection from Nazi Germany in the British eugenics movement generally, in 1939 Blacker was still convinced that the results of the Nazi sterilisation experiments were 'substantial and indeed remarkable'. (Quoted in Jones, op. cit., p. 145.)

48. As Blacker admitted (Blacker, op. cit., p. 90). The anti-eugenist John Gray claimed that the persecution of Jews in Germany had done more to shake the British faith in eugenist solutions than had a generation of disinterested research. (J.L. Gray, The Nation's Intelligence (1936), p. 22.)

49. Blacker, op. cit., pp. 54-55.

50. Ibid., p. 74.

51. Easterbrook, op. cit., p. 596.

52. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 14.

53. The Cathcart Report, para. 274.

54. One Hundred and Twenty-Third Annual Report, For the Year 1935, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 9.

55. Easterbrook, op. cit., p. 597.

56. Searle, Eugenics and Politics, pp. 163-64.

57. The Cathcart Report, paras. 255 and 268.

58. Ibid., para. 267. This appears a surprising conclusion for someone associated with the eugenics movement, but Dr. Dawson believed that not enough was known about the inheritance of intelligence to justify the prognosis of intellectual decline.

59. Easterbrook, op. cit., p. 600.

60. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 10-11.

61. Gray, op. cit., p. 22.

62. Lyndsay A. Farrall, 'The History of Eugenics: A Bibliographical Review', Annals of Science 36, No. 2 (March 1979), p. 117.

63. Though MacKenzie contends it had lost its impetus by 1918. (Donald MacKenzie, 'Eugenics in Britain', Social Studies of Science 6, Nos. 3 and 4 (September 1976), p. 518.)

64. Between 1907 and 1940 thirty of the United States introduced legislation permitting the sterilisation of the mentally disordered. During the period, over 18,000 mentally ill persons and over 17,000 'others' - the majority of them mental defectives - were sterilised. (Gerald N. Grob, 'Mental Retardation and Public Policy in America: A Research Agenda', History of Education Quarterly 26, No. 2 (Summer 1986), pp. 312-13.

65. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 14.

66. Notes of the Quarter, Eugenics Review 23, No. 3 (October 1931), p. 199.

67. Farrall, The Origins and Growth of the English Eugenics Movement 1865-1925 (1982), p. 1.

68. The growth of mental testing is described in chapter 4.

69. Child guidance clinics are discussed in chapter 4, and out-patient clinics, nursing homes etc. in chapter 5.

70. Those nineteenth-century asylum superintendents who stressed that the patient was a rational being and aimed to minimise coercion.

71. Spinning, clothes-making and knitting were practised by patients in Glasgow Royal Asylum as early as 1817. (Frank Rice, 'Care and Treatment of the Mentally Ill' in Olive Checkland and Margaret Lamb (eds.), Health Care as Social History: The Glasgow Case (1982), p. 66.

72. In the nineteenth century the form of occupation undertaken by the patient was largely determined by his social class. Dow states that males 'of the rank of gentlemen' felt degraded by manual labour and spent most of their time in amusements. (Derek A. Dow, '"Lost to his country as well as to his friends ": Voluntary Hospitals and Working Men', Scottish Industrial History 8.1 (1985), p. 39). Rice concurs that occupation was 'one aspect of the moral management regime which private patients felt they could do without'. (Francis J. Rice, 'Class and the Treatment of the Insane in Mid-Nineteenth Century Scotland', Scottish Labour History Society Journal No. 20 (1985), p. 48.

73. Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1925, pp. 11-13.

74. One Hundred and Fourteenth Annual Report of the Royal Edinburgh Hospital For the Year 1926, pp. 12-13.

75. Easterbrook, op. cit., p. 509.

76. Dr. Henderson was convinced of the 'extreme benefit' of O.T. (One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, p. 24.) Professor Robertson found it 'a useful adjunct to the ordinary methods of treatment' (One Hundred and Fourteenth Annual Report of the Royal Edinburgh Hospital For the Year 1926, p. 12), while Dr. Easterbrook found it yielded good results (Easterbrook, op. cit., p. 515).

77. It praised O.T. as 'health giving and sedative'. (Nineteenth Annual Report of the General Board of Control for Scotland For the Year 1932 ,PP 1932-33, xiv, Cmd 4431, p. xvii.)

78. Ibid., pp. xvii-xix.

79. Professor Robertson stated that the economic value of the therapy was of no consequence, but that the influence it exerted on the individual was 'beyond price'. (One Hundred and Fourteenth Annual Report of the Royal Edinburgh Hospital For the Year 1926, p. 13.)

80. The Dumfries and Galloway Courier and Herald, 19 October 1938, praised the facilities, which included a cinema and concert hall, a hairdressing salon, library, gymnasium and swimming pool. (Easterbrook, op. cit., pp. 607-8.)

81. One Hundred and Fifth Annual Report of the Royal Edinburgh Asylum For the Year 1917, p. 20.

82. One Hundred and Ninth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1921, p. 26.

83. One Hundred and Thirteenth Annual Report of the Royal Edinburgh Hospital For the Year 1925, p. 8.

84. One Hundred and Eighth Annual Report of the Royal Edinburgh Mental Hospital For the Year 1920, p. 19.

85. One Hundred and Tenth Annual Report of the Royal Edinburgh Hospital For the Year 1922, p. 20.

86. Ibid., pp. 20-21.

87. Ibid., pp. 20-21.

88. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 15, and One Hundred and Twenty-Second Annual Report, For the Year 1934, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 14.

89. Easterbrook, op. cit., p. 577.

90. Professor Robertson, for example, despite his enthusiasm for Freudian psychoanalysis, was prepared to try other methods, and even allowed patients to be treated by Christian Science 'healers', who used 'suggestion'. (One Hundred and Eleventh Annual Report of the Royal Edinburgh Hospital For the Year 1923, pp. 15-16.)

91. L.S. Hearnshaw, A Short History of British Psychology 1840-1940 (1964), p. 241. Drever was successively Combe Lecturer and Reader in Psychology at Edinburgh University, and became Professor of Psychology in 1931.

92. The contemporaneous recognition of the importance of psychological growth during childhood, which Freudian concepts also contributed to, is described in chapter 4.

93. The only training for psychiatric social work in the period was that on the Mental Health Course at the London School of Economics, which began in 1929. (Noel Timms, Psychiatric Social Work in Great Britain 1939-1962 (1964), pp. 13-14.)

94. One Hundred and Fourteenth Annual Report of the Royal Edinburgh Hospital For the Year 1926, p. 11.

95. One Hundred and Twenty-First Annual Report, For the Year 1933, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 10.

96. H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 (1974), pp. 122-23.

97. One Hundred and Twenty-Second Annual Report, For the Year 1934, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 14.

98. The condition had been identified in 1822, but its cause was not established until 1911. (One Hundred and Twelfth Annual Report of the Royal Edinburgh Hospital For the Year 1924, pp. 18-19.

99. One Hundred and Eleventh Annual Report of the Royal Edinburgh Hospital For the Year 1923, p. 17. Professor Robertson likened it to 'setting a thief to catch a thief'.

100. Ibid., p. 18.

101. Oral information from Professor R.E. Kendell, University of Edinburgh Department of Psychiatry, interviewed 23 June 1986.

102. One Hundred and Eighteenth Annual Report of the Glasgow Royal Mental Hospital For the Year 1931, pp. 23-24.

103. Annual Report of Aberdeen Royal Mental Hospital For the Year Ended 31 December 1927, p. 11.

104. As at the Crichton Royal Institution (Easterbrock, op. cit., p. 578).

105. Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, PP 1938-39, xii, Cmd 5970, p. xxii.

106. By the mid-1930s general paralysis was responsible for only 5 or 6 per cent of all admissions to the Royal Edinburgh Hospital, as compared to 10-20 per cent before World War One. (One Hundred and Twenty-First Annual Report, For the Year 1935, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 11.

107. The number of deaths from general paralysis, and other syphilitic affections of the brain, in Scottish asylums fell from 201 in 1921 to 67 in 1936. (Twenty-Fourth Annual Report of the General Board of Control for Scotland For the Year 1937, PP 1937-38, xiii, Cmd 5715, p. xxii.) The total had fallen to 50 by 1938. (Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, PP 1938-39, xii, Cmd 5970, Appendix, Table xii, pp. 26-29).

108. One Hundred and Twenty-Fifth Annual Report, For the Year 1937, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 12.

109. A drastic lowering of the blood sugar which led to unconsciousness.

110. One Hundred and Twenty-Sixth Annual Report, For the Year 1938, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 12-13.

111. Information from Professor Kendell.

112. One Hundred and Twenty-Sixth Annual Report, For the Year 1938, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 13.

113. Information from Professor Kendell.

114. Twenty-Fifth Annual Report of the General Board of Control for Scotland For the Year 1938, pp. xxiii-xxiv.

115. Information from Professor Kendell.

116. Inflammation of the brain.

117. Easterbrook, op. cit., p. 598.

118. One Hundred and Sixth Annual Report of the Royal Edinburgh Hospital for Mental and Nervous Disorders For the Year 1928, p. 14.

119. The Cathcart Report, para. 695. Dr. MacNiven, previously Deputy Physician-Superintendent at the Edinburgh Royal Hospital, succeeded Dr. Henderson in Glasgow in 1932.

120. Easterbrook, op. cit., p. 598, and The Cathcart Report, para. 695.

121. Report of Commissioner of Board of Control (8 and 9 December 1932, H.C. Marr), in the One Hundred and Twentieth Annual Report, For the Year 1932, of the Royal Edinburgh Hospital For Mental and Nervous Disorders, p. 41. Marr recommended X-ray treatment, hydrotherapy, light treatment, massage and mechanical exercises as possibilities.

Chapter 7: Footnotes

1. John S. Gibson, The Thistle and the Crown: A History of the Scottish Office (1985), pp. 93-94. The Committee comprised representatives of local authorities, educational interests and voluntary organisations.

2. S.E.D., Summary Report on Education in Scotland For the Years 1939 and 1940, PP 1940-41, iv, Cmd 6317, pp. 7-8.

3. Ibid., p. 14.

4. Under the National Service Order all women teachers were reserved, but by the beginning of 1941 virtually all male teachers under thirty had been called up (ibid., p. 12, and S.E.D., Summary Report on Education in Scotland For the Year 1941, PP 1941-42, iv, Cmd 6370, p. 8).

5. City and Royal Burgh of Edinburgh, Eleventh Annual Progress Report of the Education Committee Session 1939-40, pp. 8, 34.

6. H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 (1974), p. 128.

7. R.M. Titmuss, Problems of Social Policy (1950).

8. Gibson, op. cit., p. 95.

9. City and Royal Burgh of Edinburgh, Eleventh Annual Progress Report of the Education Committee Session 1939-40, p. 19 and Tenth Annual Progress Report of the Education Committee Session 1938-39, p. 14.

10. S.R.O. ED/174 (1951-57), Child Guidance Clinics, Memorandum on 'The Child Guidance Service in Scotland' (n.d.) [hereinafter cited as Child Guidance Memorandum]. The clinic had originally been opened, in 1940, as a special school and hostel (The Corporation of Glasgow Education Department, Report on Child Guidance Service Session 1956-57, p. 7 [hereinafter cited as Glasgow Clinics 1956-57].

11. Glasgow Clinics 1956-57.

12. Catherine M. McCallum, 'Child Guidance in Scotland', Symposium on Psychologists and Psychiatrists in the Child Guidance Service, British Journal of Educational Psychology 22, Part 1 (February 1952), p. 81.

13. Ibid., p. 81.

14. Child Guidance Memorandum.

15. S.R.O. HH65/64 (1942-43), Committee on Post-War Hospital Problems in Scotland, Memoranda, Notes etc. [hereinafter cited as Hetherington Memoranda etc.], D.H.S. Memorandum on the Emergency Hospital Scheme (n.d.) [hereinafter cited as D.H.S., E.H.S.].

16. Report of the Department of Health for Scotland For the Period July 1945 to December 1946, PP 1946-47, xii, Cmd 7188, p. 37.

17. Annual Report of the General Board of Control for Scotland For the Year 1954, PP 1955-56, xxii, Cmd 9552, p. 5.

18. Hetherington Memoranda etc., D.H.S., E.H.S.

19. Two theatres were provided at Gartloch, three at Larbert and seven at Bangour (ibid., D.H.S. E.H.S.).

20. Eleven new huts provided 462 extra beds at Gartloch, twenty-one provided 882 new beds at Larbert, twelve provided 504 new beds at Lennox Castle, and 1,680 extra beds were provided in forty new huts at Bangour (ibid., D.H.S., E.H.S.).

21. Ibid., D.H.S. Memorandum, 'Staffing of the Emergency Hospitals' (n.d.).

22. Ibid., Draft D.H.S. Circular 310/1941, 19 December 1941 [hereinafter cited as E.H.S. Circular 1941].

23. Report of the Department of Health for Scotland For the Period July 1945 to December 1946, p. 37.

24. Tait, op. cit., p. 130.

25. Report of the Department of Health for Scotland For the Period July 1945 to December 1946, p. 40.

26. The Committee had been convinced that an integrated service, in which the voluntary hospitals would accept a measure of supervision and guidance from the D.H.S., was essential, and recommended that the five regions of Scotland should each have a regional advisory committee representing voluntary and statutory hospitals to facilitate co-operation among hospitals (D.H.S., Report of the Committee on Scottish Health Services (1936), PP 1935-36, xi, Cmd 5204, chapters xi-xiii and xxii.

27. Hetherington Memoranda etc., E.H.S. Circular 1941. The new institution at Carstairs, completed first prior to the outbreak of war, had been intended to house the inmates of the Criminal Lunatic Department at Perth Prison, and the dangerous or violent mental defectives who were also there, but it had instead been used for emergency purposes (Annual Report of the General Board of Control for Scotland For the Year 1954, p. 8.

28. Information from Fiona R. Watson, Archivist, Grampian Health Board, 3 February 1984.

29. Dr. Chambers, Physician-Superintendent of the Murray Royal, Perth, asserted that patients' relatives could not understand the inconsistent policy of the Ministry in refusing to grant a pension in the majority of cases, but granting it to a minority (One Hundred and Nineteenth Annual Report of James Murray's Royal Asylum, Perth [for the year ended 31 March 1946], pp. 12-13).

30. Professor Henderson, who had been at the forefront of those urging such measures, praised the excellent work of Civilian Medical Boards in rejecting unsatisfactory candidates, and the efforts which were made to place personnel in the forms of work which were most suitable for them (One Hundred and Thirty-Third Annual Report, For the Year 1945, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 8-9.

31. It is difficult to form an accurate picture of the overall position, but it appeared that, as compared to World War One, asylums were not admitting large numbers of ex-servicemen (ibid., p. 9).

32. Information from Fiona R. Watson.

33. Harry Stalker, 'The Next Fifty Years 1927-1977', in Murray Royal Hospital Perth 1827-1977 (n.d.), p. 28.

34. Summary Report of the Department of Health for Scotland For the Year ended 30 June 1943, PP 1942-43, iv, Cmd 6462, p. 12 and Summary Report of the Department of Health for Scotland For the Year ended 30 June 1944, PP 1943-44, iii, Cmd 6545, p. 16.

35. These measures were not very popular with some superintendents since, as Professor Henderson believed, an unhappy nurse was almost as bad as no nurse (One Hundred and Thirty-Second Annual Report, For the Year 1944, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 12-13.

36. Pentothal, an intravenously administered barbiturate with a sedative effect, appeared to be the drug most commonly used for the purpose.

37. It is difficult to provide any precise statistical information but in Edinburgh, for example, a 'large number' of operations were carried out at the Neuro-Surgical Unit at the Royal Infirmary (Annual Reports of the Royal Edinburgh Mental Hospital 1943-45).

38. One Hundred and Thirty-First Annual Report, For the Year 1943, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 12.

39. The General Board of Control did not publish an annual report in the years 1939-53 and in the war years the Department of Health published only brief summary reports which did not include mental health statistics.

40. Summary Report by the Department of Health for Scotland For the Year Ended 30 June 1942, PP 1941-42, iv, Cmd 6372, p. 3.

41. Hansard, 9 October 1941, Vol. 374, cols. 116-20.

42. Of 'Want, Disease, Ignorance, Squalor and Idleness' (Social Insurance and Allied Services: Report by Sir William Beveridge (1942), 1942-43, vi, Cmd 6404, para. 456).

43. Ibid., para. 426.

44. Hansard, 16 February 1943, Vol. 386, cols. 1655-64.

45. As the Secretary of State asserted (S.R.O. HH101/1 (1943-44), N.H.S., General Policy and Pre-White Paper Preparation [hereinafter cited as N.H.S. Pre-White Paper], 'National Medical Service, Note of Meeting with Representatives of the Voluntary Hospitals on 12 March 1943').

46. Gibson, op. cit., p. 113.

47. The material in the N.H.S. Pre-White Paper file makes it clear that the discussions which took place in Spring 1943 were conducted on this assumption, but it is not clear precisely when the decision to exclude the mental health service was taken.

48. N.H.S. Pre-White Paper, letter from Pater to R. Howat, D.H.S., 19 April 1943.

49. Ibid., Pater to Howat.

50. Ibid., D.H.S. minute, 24 April 1943.

51. Ibid., Letter from Howat to Pater, 13 April 1943.

52. Ibid., Howat to Pater.

53. Ibid., Letter from G.H. Henderson, D.H.S., to Sir John Maude, Ministry of Health, 14 May 1943.

54. Ibid., Henderson to Maude.

55. Ibid., Note from Jeffrey to Henderson, 15 May 1943.

56. Ibid., D.H.S. minute 24 April 1943.

57. Hansard, 15 April 1943, Vol. 388, col. 1401 and 27 May 1943, Vol. 389, cols. 1716-17. Both answers were given in reply to questions from R.G. Sorensen M.P. (Leyton West).

58. S.R.O. HH101/2 (1943), N.H.S., Committee on Reconstruction priorities, Hospital Schemes, White Paper [hereinafter cited as N.H.S. Reconstruction etc.], Memorandum by the Minister of Health [n.d. but Summer (July?) 1943].

59. Ibid., Memorandum by the Secretary of State [July?] 1943. The Secretary was in general agreement with the Minister's memorandum but did not specifically mention its mental health aspects.

60. N.H.S. Pre-White Paper, Letter from Henderson to Maude, 14 May 1943. The Minister's announcement was made thirteen days later.

61. N.H.S. Reconstruction etc., Memorandum by the Minister of Health [July?] 1943.

62. The Committee concurred with the inclusion of the mental health service in the N.H.S., but felt that its remit did not permit it to comment further, although one of the members of the Committee, Professor Henderson, regretted that they had not considered the administrative organisation of the service and emphasised that the prospective N.H.S. should include provisions for the treatment of incipient mental and nervous conditions (D.H.S., Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws (1946), PP 1945-46, xiii, Cmd 6834, Reservations, p. 119).

63. S.R.O. HH101/4 (1943-45), N.H.S., Consultations with Local Authorities [hereinafter cited as N.H.S., L.A.s], 'N.H.S.(S) L.A. 26, N.H.S. Local Authority Associations' Liaison Committee, Fourth Meeting with L.A.A.L.C. held ... on ... 10 July 1944' [hereinafter cited as L.A.A.L.C. July 1944].

64. Ibid., L.A.A.L.C. July 1944, and S.R.O. HH101/3 (1944), N.H.S., Setting Up Timetable, D.H.S. note, 21 February 1944.

65. N.H.S. Reconstruction etc., Memorandum by the Minister of Health [July?] 1943.

66. N.H.S. Pre-White Paper, D.H.S. Memorandum (agreed with the Secretary of State and the Minister of Health) on the N.H.S., 2 March 1943.

67. Ibid., 'National Medical Service, Note of Meeting with Representatives of the Local Authorities Associations on 8 March 1943', 10 March 1943.

68. Ibid., 'National Medical Service, Note of Meeting with the Medical Profession on 8 March 1943', 8 March 1943.

69. Ibid., Note from 'M.R.' to Howat [n.d., but Spring (March?) 1943] reporting Inch's views.

70. Ibid., M.R. to Howat.

71. Ibid., Press Release, 12 March 1943.

72. Ibid., Letter from Robert Barclay to Henderson, 23 February 1943. Barclay was the Chairman of the Scottish Branch of the British Hospitals' Association.

73. S.R.O. HH65/57 (1943-45), Post-War Hospital Problems in Scotland, Report of the Hetherington Committee [hereinafter cited as Hetherington, Report etc.], Note of Meeting between the Secretary of State and Representatives of the Scottish Voluntary Hospitals on 13 January 1944.

74. D.H.S., Report of the Committee on Post-War Hospital Problems in Scotland (1943), PP 1942-43, iv, Cmd 6472, passim. The Committee also recommended that treatment and maintenance in hospital should be free, or at least that no attempt should be made to recover the cost at or near the time of treatment.

75. Hetherington, Report etc., The B.H.A. Scottish Branch, Comments by the Executive Committee on the Report, January 1944.

76. Ibid., 'Hospitals in Post-War Scotland, B.M.A. Views on Hetherington Report', extract from Glasgow Herald 29 October 1943.

77. M.O.H./D.H.S., A National Health Service (1944), PP 1943-44, viii, Cmd 6502, chapter ii, passim.

78. Ibid., chapter viii, passim.

79. Ibid., chapter vii, passim.

80. Ibid., chapter ii, p. 9.

81. N.H.S. Pre-White Paper [sic], Extract from M.A.C.(S) Mins. 7, Meeting on 12 May 1944. It is not clear what the abbreviation represents, but the meeting was attended by Henderson and other D.H.S. officers.

82. N.H.S., L.A.s, D.H.S. Memorandum, 'The Place of Mental Health', 6 June 1944 [hereinafter cited as Mental Memorandum June 1944]. Local authority representatives, however, felt that local authorities should share responsibility with the J.H.B.s (ibid., L.A.A.L.C. July 1944).

83. Ibid., Mental Memorandum June 1944.

84. Ibid., Mental Memorandum June 1944 and L.A.A.L.C. July 1944.

85. S.R.O. HH101/959 (1945-46), N.H.S., General Policy, Functions of General Board of Control [hereinafter cited as N.H.S. General Board], D.H.S. Memorandum, 'The General Board of Control for Scotland', 7 June 1945.

86. Ibid., Letter from P. Barter, Ministry of Health and English Board of Control, to T.D. Haddow, D.H.S., 23 July 1945.

87. Ibid., 'N.H.S., Note of Meeting with English Board of Control and Ministry of Health on 19 July 1945', 21 July 1945.

88. Brian Abel-Smith, The Hospitals 1800-1948: A Study in Social Administration in England and Wales (1964), pp. 473-76.

89. N.H.S., L.A.s, Memorandum, 'Proposals for a National Health Service in Scotland'. The memorandum is undated but it was made available to the local authority representatives in January 1946.

90. Section 80 of the Act stipulated that 'illness' included mental illness.

91. The constitution of R.H.B.s was laid down in Part I of the First Schedule of the Act. As well as making provision for 'mental health' members it provided that the Boards' chairmen and members would be appointed by the Secretary of State following consultations with L.H.A.s, doctors' representatives and the universities.

At least half of the members were to be non-medical people, and all would give their services gratuitously.

92. The constitution of Hospital Management Boards was laid down in Part III of the Fourth Schedule which again provided that half of the members were to be non-doctors, and that they were to be appointed after consultations with a variety of interested parties. They, too, would be unpaid.

93. Section 51(3) provided that an L.H.A. could make arrangements with voluntary organisations for the performance of any services connected with the L.H.A.'s duties under the Mental Deficiency Acts or under sections 49-51 of the N.H.S. Act, and authorised L.H.A.s to contribute to the voluntary organisation's costs.

94. The Board however continued to stress the importance of special sub-committees and eventually, and somewhat reluctantly, the D.H.S. included a reminder of the advisability of such sub-committees in a circular of August 1947 (S.R.O. HH61/154 (1947-49), N.H.S. (Scotland) Act 1947, L.H.A. Administrative Schemes, General Policy).

95. The Board therefore retained such functions as the keeping of records of mental patients and defectives, dealing with requests for discharge, the periodic review of cases, the approval of applications for voluntary admission and the visitation of patients placed under private care.

96. Section 49(5) of the Act also transferred to the Board the entire management of the State Institution for violent or dangerous defectives, which was not included in the normal R.H.B./B.O.M. structure.

97. Section 49(3) of the 1947 Act, Annual Report of the General Board of Control for Scotland For the Year 1954, p. 4, and N.H.S. General Board.

98. The exceptions were the Royal mental hospitals in Glasgow, Edinburgh and Aberdeen which, as described in chapter 5, had already changed their titles.

99. These provisions were contained in the Ninth Schedule of the 1947 Act, 'Amendments and Repeal of Enactments Relating to Lunatics and Mental Defectives'.

100. Report of the Department of Health for Scotland For the Year 1948, PP 1948-49, xvii, Cmd 7659, p. 41.

101. On 30 June 1948 (ibid., p. 45).

102. Ibid., p. 45.

103. S.R.O. HH101/136 (1947-48), Regional Hospital Boards' Proposals for the Discharge of Local Authority Functions. McGregor was Medical Officer of Health in Glasgow, Macpherson and Baird were the convenors of the public health committees in Inverness Burgh

and Aberdeen City respectively, and Greenlees was Chair of the Royal Hospital for Sick Children in Edinburgh. I have been unable to find out who Hughes was.

104. S.R.O. HH101/158 (1946-51),Regional Hospital Boards, Composition and Appointment, General Policy [hereinafter cited as R.H.B.s, General], Letter of apology to Dr. Kate Fraser, 19 August 1947.

105. Report of the Department of Health for Scotland For the Year 1947, PP 1947-48, xii, Cmd 7453, p. 31. Some members of R.H.B.s were appointed to 1950, and others until 1951 and 1952, with one-third of the Board retiring in each of those years.

106. R.H.B.s, General.

107. Report of the Department of Health for Scotland For the Year 1948, p. 28.

108. S.R.O. HH101/154 (1947-51),Hospital Boards of Management, Appointment etc. Other mental hospitals with their own B.O.M. included Glasgow Royal, Hawkhead and Bellsdyke.

109. Ibid. Lanarkshire and Renfrewshire were among the other areas to group mental hospitals under separate B.O.M.s.

110. Report of the Department of Health for Scotland For the Year 1952 in Reports of the Department of Health for Scotland and the Scottish Health Services Council 1952, PP 1952-53, xiii, Cmd 8799, p. 32. In 1952, however, Craig Dunain was brought under a separate Board.

111. Information from Fiona R. Watson.

112. In England, too, mental hospitals were, with very few exceptions, formed into separate groups apart from general hospitals (Abel-Smith, op. cit., p. 490).

113. Report of the Department of Health for Scotland For the Year 1948, p. 28.

114. Stalker, op. cit., p. 31.

115. Report of the Department of Health for Scotland For the Year 1948, p. 28.

116. One Hundred and Nineteenth Annual Report of James Murray's Royal Asylum, Perth [for the year ended 31 March 1946], p. 17.

117. Ibid., pp. 13-14. The concept of a ban on treatment outside the region of domicile was particularly alarming for the Murray Royal, which accommodated (private) patients from all over Scotland, England and Ireland; in the mid-1940s, barely one-fifth of its patients were from the Perth area.

118. Ibid., p. 17.

119. One Hundred and Thirty-Fifth Annual Report of the Royal Edinburgh Hospital For the Year 1947, pp. 12-13.

120. S.R.O. HH101/364 (1947-52),N.H.S. (Scotland) Act 1947, Position in the N.H.S., James Murray's Royal Asylum, Perth. The D.H.S. based its decision on advice that a hospital like the Murray, which ploughed back into the hospital the profits it made, was not 'carried on for profit' and was thus a voluntary hospital, and transferable.

121. S.R.O. HH101/273 (1947-49),N.H.S. (Scotland) Act 1947, Position in the N.H.S., Royal Mental Hospital, Glasgow.

122. S.R.O. HH101/336 (1947-48),N.H.S. (Scotland) Act 1947, Position in the N.H.S., St. Charles' Institution for Mental Defectives, Carstairs.

123. In a few cases, however, transfer was delayed; for reasons which are not clear, the transfer of Baldovan mental deficiency institution had still not been completed by March 1949 (S.R.O. HH101/351 (1947-50),N.H.S. (Scotland) Act 1947, Position in the N.H.S., Baldovan Institution).

124. Report of the Department of Health for Scotland For the Year 1948, p. 27 and Report of the Department of Health for Scotland For the Year 1947, p. 32.

125. Report of the Department of Health for Scotland For the Period July, 1945 to December, 1946, p. 13.

Chapter 8: Footnotes

1. W.D. Ritchie, 'Scotland', The Year Book of Education 1952, p. 183.

2. City and Royal Burgh of Edinburgh, Eleventh Annual Progress Report of the Education Committee Session 1939-40, p. 20.

3. Ibid., p. 20.

4. From November 1941 onwards the Scottish Educational Journal carried a series of articles dealing with post-war education.

5. This Committee in June 1943 published proposals for reconstruction under the title of The Scottish School (H.M. Knox, Two Hundred and Fifty Years of Scottish Education 1696-1946 (1953), p. 227).

6. Ritchie, op. cit., p. 184.

7. Section 20 of the Education (Scotland) Act 1918 had given His Majesty in Council the power to appoint an Advisory Council to advise the Department on educational matters. It was appointed, but in the intervening period it had produced only one brief and unremarkable report on technical education. Following its re-establishment, it reported on citizenship, teachers' training and primary and secondary education. Its subsequent reports on handicapped pupils are discussed later in this chapter.

8. Brian Holmes, 'The Reform of English Education Under the 1944 Education Act', The Year Book of Education 1956, p. 229.

9. Section 1(4) stated that primary and secondary education included education by special methods or 'special educational treatment'.

10. Although section 1(4) did not qualify the Secretary of State's powers in this respect.

11. Under regulations which were to be drawn up under the terms of section 7(1).

12. Or if the child's parent required a certificate to be issued.

13. Section 6 empowered L.E.A.s to provide clinics, and prescribed their functions, while section 87 interpreted the term special school to include clinics.

14. There was no specific reference to the child guidance service in either the English Education Act 1944 or - more surprisingly, given the service's medical orientation - in the N.H.S. Act 1946. English L.E.A.s, however, could provide child guidance services under their general powers to provide medical inspection and treatment and to assess the abilities and aptitudes of children.

15. Voluntary and statutory provisions for these untrainable children are described in chapter 10.

16. Ritchie, op. cit., p. 185.

17. S.E.D., Education (Scotland) Bill. Explanatory Memorandum by the Secretary of State for Scotland (1945), PP 1944-45, x, Cmd 6602, para. 2.

18. David S. Petrie, 'The Development of Special Education in Scotland Since 1950', in W.B. Dockrell, W.R. Dunn and A. Milne (eds.), Special Education in Scotland (1978), p. 2 [hereinafter cited as Special Education].

19. S.R.O. ED28/162 (1951-55), Working Party on Provision for Handicapped Children [hereinafter cited as Working Party, Handicapped]. Dr. Jardine made his remark in an address to a conference on handicapped children, held under the auspices of the Association of Directors of Education in Scotland and the Scottish Council for Health Education held in December 1950, over which he presided.

20. They were Pupils who are Defective in Hearing (1950), Pupils who are Defective in Vision (1950), Pupils with Physical Disabilities (1951), Pupils with Mental or Educational Disabilities (1951), Pupils Handicapped by Speech Disorders (1951), Pupils who are Maladjusted because of Social Handicaps (1952) and The Administration of Education for Handicapped Pupils (1952). The Council comprised representatives of educational interests including L.E.A.s, the E.I.S. and the A.D.E.S.

21. S.E.D., Pupils with Mental or Educational Disabilities: A Report of the Advisory Council on Education in Scotland (1951), PP 1951-52, x, Cmd 8401, para. 24 [hereinafter cited as Report on Mental Disability].

22. Children who, because of their lack of ability or bad influence on others, were unsuitable for L.E.A. junior centres must, the Council asserted, receive such care as could be provided by the mental deficiency authority (ibid., para. 70).

23. S.R.O. ED28/7 (1952-62), Special Educational Treatment Regulations (Scotland) 1954, Notes, Circulars, etc. The other categories were the deaf, partially deaf, blind, partially sighted, epileptics, pupils with speech defects, the maladjusted and the physically handicapped.

24. The English 'E.S.N.' group was defined by the School Health Service and Handicapped Pupils Regulations 1953 as those who, by reason of limited ability or other conditions, required 'some specialised form of education wholly or partly in substitution for the education normally given in ordinary schools' (D.G. Pritchard, Education and the Handicapped 1760-1960 (1963), p. 211.

25. S.E.D. Circular No. 300, The Education of Handicapped Pupils, 21 March 1955, para. 42 [hereinafter cited as Circular 300].

26. Report on Mental Disability, para. 17.

27. Circular 300, para. 4.

28. Report on Mental Disability, para. 127. The Advisory Council did not feel able to make any estimate of the shortfall in provision for the ineducable but trainable category for whom L.E.A.s had only recently assumed responsibility (ibid., para. 97).

29. Circular 300, paras. 7 and 42. The Council recognised that its estimate was approximate and that adjustments would have to be made for local conditions (Report on Mental Disability, para. 96).

30. D.H.S., The Welfare Needs of Mentally Handicapped Persons: Report by a Committee of the Scottish Advisory Council on the Welfare of Handicapped Persons (1957), paras. 9-10.

31. The length of time the report was delayed is not clear, but it is clear that the gap between the start of work in May 1952 and publication in 1957 was at least partly the result of deliberate policy (S.R.O. ED28/181 (1956-62), Mentally Handicapped Children, General). The report was eventually issued with D.H.S. Circular 17/1957, which stressed the 'long-term character' of the proposals: a copy of the circular is included in S.R.O. HH61/56 (1954-55), Education of Handicapped Pupils, Reports of the Advisory Council on Education in Scotland, Comments by Department of Health for Scotland etc. [hereinafter cited as Working Party, Draft Report].

32. Report on Mental Disability, paras. 149-64.

33. Circular 300, para. 43.

34. Ibid., para. 9.

35. Report on Mental Disability, paras. 167-68.

36. Circular 300, paras. 10 and 43.

37. S.E.D., The Administration of Education for Handicapped Pupils: A Report of the Advisory Council on Education in Scotland (1952), PP 1951-52, x, Cmd 8432, paras. 5-7. The Council envisaged that this body would include representatives of L.E.A.s, teachers, psychologists, administrators and school medical officers.

38. Circular 300, para. 61. The Working Party, like the conference out of which it grew, was chaired by Dr. Jardine. Its membership - which included representatives of the A.D.E.S., the E.I.S., the Associations of Medical Officers of Health and of School Medical Officers and the Scottish Association for Mental Health, was in fact similar to that envisaged by the Advisory Council for the proposed official body. The Working Party held its first meeting in March 1952 (Working Party, Handicapped).

39. Report on Mental Disability, paras. 49-70 and Circular 300, para. 42. The type of provision at which the trial period was given would depend on whether the child was on the borderline between normality and handicap (when the trial would be in an ordinary

school) or educability and trainability (traditional special school) or trainability and untrainability (L.E.A. junior centre).

40. However, the Secretary of State preferred to use 'mentally handicapped' rather than the Advisory Council's term 'retarded' to describe higher-grade defectives (Circular 300, para. 41).

41. James Scotland, The History of Scottish Education Volume Two (1969), p. 190.

42. Information from the S.E.D.'s Annual Reports on Education in Scotland, 1954-60.

43. Dr. H. Stewart Mackintosh, Director of Education, Glasgow, at the conference on handicapped children held in December 1950 (Working Party, Handicapped).

44. As Dr. Mackintosh argued (ibid.).

45. The Advisory Council reflected this view (Report on Mental Disability, paras. 134-35).

46. Knowetop School, Motherwell had eight mentally and four physically defective classes (and a mixed class) in 1951, while, in the same year, Auchinraith School, Hamilton, had seven and four classes for the mentally and physically handicapped respectively (S.R.O. ED28/170 (1951-53), Copies of Inspectors' Reports [hereinafter cited as Inspectors' Reports].

47. S.R.O. ED28/173 (1948-53), Inspection of Certified Institutions.

48. Dr. Jardine's remark, at the 1950 conference on the handicapped, that it was a pity that so many children had to be sent to institutions because of the lack of educational provision, however, suggests that it was a significant problem (Working Party, Handicapped). So, too, does the fact that Circular 300 specifically deplored the practice (Circular 300, para. 43).

49. S.R.O. ED28/183 (1946-51), Establishment of Residential School for Mentally Handicapped Children in the Highland Area.

50. Raddery House School, Fortrose, was opened in October 1955 (S.E.D., Education in Scotland in 1955, PP 1955-56, xiv, Cmd 9722, p. 48).

51. The 7,344 mentally handicapped pupils in special schools and classes (including junior occupation centres) on 15 January 1960 included fifty-seven pupils at residential schools (S.E.D., Education in Scotland in 1960, PP 1960-61, xiii, Cmnd 1359, Table 4, pp. 116-17).

52. In 1959, for example, plans were approved for a new secondary school for mentally handicapped pupils in Glasgow (S.E.D., Education in Scotland in 1959, PP 1959-60, xii, Cmnd 1018, p. 26).

53. At least one special school insisted that every boy had to hand-sew a pair of trousers for himself before he left school (Petrie, Special Education, p. 7).

54. Some schools, however, circumvented the problem by using the services of visiting teachers on a part-time basis (Inspectors' Reports).

55. S.E.D., Education in Scotland in 1951, PP 1951-52, x, Cmd 8515, p. 62.

56. The new course followed the same pattern as the previously described Jordanhill course (Marion Blythman, 'The Training of Teachers for Special Education in Scotland', in Dockrell et al., op. cit., pp. 41-42).

57. Petrie, Special Education, p. 9.

58. The average number of mentally handicapped pupils on the registers of special schools and classes during the session 1946-47 was 5,938. There were 7,120 mentally handicapped pupils in special schools and classes on 15 January 1957 (S.E.D., Education in Scotland in 1948, PP 1948-49, xiv, Cmd 7656, p. 17 and S.E.D., Education in Scotland in 1957, PP 1957-58, x, Cmd 407, Table 3, p. 92.

59. Working Party, Handicapped. The revised report was originally included in S.E.D. Circular No. 384/D.H.S. Circular 80/1958, Working Party on the Provision for Handicapped Children, 4 September 1958 [hereinafter cited as Circular 384]. However, the report is no longer included in the copy of the circular in the N.L.S., and I have been unable to locate it. The 1954 version of the report, however, is included in the S.R.O. file Working Party, Draft Report.

60. The 1954 version of the report not only provided an estimate of the number of mentally handicapped pupils in each L.E.A. area but also of the number in each area who were likely to require day special schools, residential special schools and junior occupation centres. It concluded that there were 12,065 children in Scotland who required day schools, 1,609 who required residential schools, and 1,609 who needed junior centres (Working Party, Draft Report).

61. Circular 384, paras. 2-3.

62. S.E.D., Degrees of Mental Handicap: Report of the Working Party on Standards of Ascertainment for Scottish Schoolchildren (1961), para. 6 [hereinafter cited as Degrees of Handicap].

63. Precise figures are not available. However, the parents of children ascertained to require S.E.T. could, under the terms of section 55(2) of the 1946 Education Act, appeal to the Secretary of State against the decision, and appeals were made every year. In most instances the L.E.A.'s decision was upheld, but in a substantial (but varying) minority of cases the L.E.A. was directed to give the child a trial in an ordinary school. The parents of children diagnosed as ineducable could, under the terms of section 56 of the Act, similarly appeal, and again some children subsequently received a probationary period in a special

school (Information from the S.E.D.'s Annual Reports on Education in Scotland, 1948-60).

64. Degrees of Handicap. The Working Party included representatives of the Scottish branches of the Royal Medico-Psychological Association, the Society of Medical Officers of Health and the Special Schools Association, as well as of the Association of Directors of Education in Scotland.

65. Petrie, Special Education, p. 10.

66. Degrees of Handicap, para. 16.

67. Ibid., chapter 2, passim.

68. Ibid., paras. 34-35. Among the criteria which a child should be able to satisfy if he or she was to benefit from a special school were the abilities to share, co-operate and accept discipline, to settle at a given task, to follow instructions, use a reasonable vocabulary and to show some degree of independence.

69. The Working Party recommended that children should attend junior occupation centres if (though unable to satisfy the criteria in note 68), they could, by the age of seven, communicate, feed themselves, associate with other children and not be unduly distressed at separation from their parents (ibid., paras. 46-47).

70. Ibid., paras. 41 and 48.

71. Ibid., para. 38. The possible exceptions were children suffering from certain clinical conditions (which were not specified).

72. The major one being that if a child did not, after the age of seven and after a trial period, satisfy the criteria (note 69) for attendance at an occupation centre, then it was doubtful whether an occupation centre was appropriate (ibid., para. 47).

73. The untrainable category was finally abolished by the Education (Mentally Handicapped Children) (Scotland) Act 1974.

74. Petrie, Special Education, p. 9.

75. R.N. Jackson, Review of Special Education in Scotland by Dockrell et al., Scottish Educational Review 11, No. 1 (May 1979), p. 80.

76. Degrees of Handicap, para. 31. Some J.O.C. pupils may even have previously attended an ordinary school.

77. Ibid., para. 30.

78. S.R.O. ED28/271 (1947-56), Mentally Handicapped Children, General. S.A.M.H., 'Report on the Work of the Association by Sir Hugh Rose ... President ... at the A.G.M. ... 15 October 1949'. It seems likely, however, that the Association was primarily concerned with training instructors for the centres for untrainables which it conducted.

79. Petrie, Special Education, pp. 10-11. The course consisted of two short summer courses separated by a year of supervised teaching practice.

80. The Scottish Health Services Council in 1954 reported that there was stiff competition for occupation centre posts (Report of the Scottish Health Services Council in Reports of the Department of Health for Scotland and the Scottish Health Services Council 1954, PP 1954-55, v, Cmd 9417, p. 143).

81. Ibid., p. 143.

82. D.H.S., S.H.S.C., Mental Health Legislation: Second Report by a Committee Appointed by the Council (1959), paras. 25-29.

83. Ibid., para. 28. It was difficult to assess whether this was the case, and the Committee felt that it was of rather less weight than it was believed to be by those in the educational field. There is no doubt, however, that expert opinion believed that parents would object to the proposed transfer of junior centres.

84. N.L.S. Acc 7170, Scottish Association for Mental Health, Box 2, File 4, Minutes, 17 January 1959-29 November 1960.

85. Again, this is discussed in chapter 10.

86. S.E.D., Education in Scotland in 1957, pp. 20-21.

87. Ibid., p. 21 and S.E.D., Education in Scotland in 1960, Table 4, pp. 116-17.

88. Working Party, Draft Report.

89. Petrie, Special Education, p. 11.

90. S.R.O. ED28/174 (1951-57), Child Guidance Clinics [hereinafter cited as Clinics 1951-57], Memorandum on 'The Child Guidance Service in Scotland' (n.d.) [hereinafter cited as Child Guidance Memorandum].

91. The Corporation of Glasgow Education Department, Report on Child Guidance Service Session 1945-46, p. 3, and S.E.D., Pupils Who Are Maladjusted Because of Social Handicaps: A Report of the Advisory Council on Education in Scotland (1952), PP 1951-52, x, Cmd 8428, para. 65 [hereinafter cited as Report on the Maladjusted].

92. Clinics 1951-57, Child Guidance Memorandum.

93. The number of cases attending Glasgow Corporation's clinics rose from 245 (1,204 attendances) in 1937 to 3,217 (25,267 attendances) in 1957 (The Corporation of Glasgow Education Department, Report on Child Guidance Service Session 1956-57, p. 5 [hereinafter cited as Glasgow Clinics 1956-57].

94. Clinics 1951-57, Child Guidance Memorandum.

95. Report on the Maladjusted, para. 57.

96. Ibid., paras. 58 and 88.

97. Ibid., paras. 66-67 and 70-76.

98. Circular 300, para. 54.

99. The training of child guidance psychologists entailed the completion of a first degree (three years) and teachers' training (eighteen months), followed by five years teaching experience, during which the B.Ed. degree (which was a prerequisite) could be taken. Appointment to the grade of Principal Educational Psychologist usually required, in addition to the above, at least five years clinical practice. Dr. Keddie of the D.H.S., in a report (to the Working Party on Handicapped Children) which included this description of the training of child guidance psychologists, expressed the view that the length and difficulty of the training was not generally recognised (Working Party, Handicapped, J.A.G. Keddie, 'Child Guidance in Scotland', 1 October 1949 [hereinafter cited as Keddie Report 1949].

100. Clinics 1951-57, Memorandum by D.S. Petrie, 20 June 1956 [hereinafter cited as Petrie Memorandum 1956].

101. Professor Henderson of the Royal Edinburgh Mental Hospital, for example, felt that child guidance clinics should be affiliated to general paediatric hospitals, and regarded the establishment of independent clinics, and of L.E.A. clinics providing psychiatric services, as 'an extremely dangerous development' (D.H.S., Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws (1946), PP 1945-46, xiii, Cmd 6834, Reservations, p. 125).

102. Gertrude Keir, 'A History of Child Guidance', Symposium on Psychologists and Psychiatrists in the Child Guidance Service, British Journal of Educational Psychology 22, Part 1 (February 1952), p. 22.

103. Clinics 1951-57, Letter from Jas. B. Frizell, A.D.E.S., to J.S. Brunton, S.E.D., 18 April 1951.

104. Ibid., Letter from [Archd. Davidson?], S.E.D., to Jas. B. Frizell, 2 May 1951.

105. Dr. Keddie felt that members of some clinical teams failed, at times, to make 'timeous' use of their colleagues' services (Working Party, Handicapped, Keddie Report 1949).

106. The Advisory Council in 1952 found that psychologists and psychiatrists in Glasgow recognised their complementary nature and worked together smoothly and efficiently (Report on the Maladjusted, para. 66). Glasgow Education Department also felt that its service had avoided internal rivalry (Glasgow Clinics 1956-57, p. 6).

107. Clinics 1951-57, Petrie Memorandum 1956.

108. There were only 'four or five' child psychiatrists in Scotland in 1959 (Report of the Department of Health for Scotland 1959, PP 1959-60, xvi, Cmnd 983, p. 36).

109. There were only three full-time child psychiatric clinics in Scotland in 1950; the one at the Edinburgh Sick Children's Hospital, Notre Dame, and a clinic in Kirkcaldy (Catherine M. McCallum, 'Child Guidance in Scotland', Symposium on Psychologists and Psychiatrists in the Child Guidance Service, B.J.E.P. 22, Part 2 (June 1952), p. 83).

110. The first children's unit in an N.H.S. mental hospital was the Ladyfield Child Psychiatric Centre opened at the Crichton Royal Hospital in 1951: similar units were opened in the South-Eastern and Western Hospital Region in 1957. There were also two psychiatric units in children's hospitals in 1957 (Report of the Department of Health for Scotland for the Year 1951 in Reports of the D.H.S. and the S.H.S.C. 1951, PP 1951-52, xv, Cmd 8496, p. 37 and Report of the Department of Health for Scotland 1957, PP 1957-58, xiv, Cmnd 385, pp. 41-42).

111. S.H.H.D., S.H.S.C., Medical Services for Child Guidance: Report by a Sub-Committee of the Standing Medical Advisory Council (1962), para. 58.

112. Working Party, Handicapped, Keddie Report 1949.

113. Report on the Maladjusted, para. 80.

114. Glasgow Clinics 1956-57, pp. 7-8.

115. Ibid., p. 8.

116. Report on the Maladjusted, para. 80.

117. Including Manchester and Liverpool (M.O.H./D.H.S., Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services (1959), para. 222).

118. The Corporation of Glasgow Education Department, Report on Child Guidance Service Session 1953-54, p. 16.

119. Notre Dame Child Guidance Clinic, Glasgow, Annual Report 1 April 1957-31 March 1958, passim.

120. Report of the Department of Health for Scotland 1957, p. 18.

121. S.E.D., Education in Scotland in 1957, p. 20.

122. Report of the Department of Health for Scotland 1961, Part 1: Health and Welfare Services, PP 1961-62, xvii, Cmnd 1703, p. 36.

Chapter 9: Footnotes

1. Report of the Department of Health for Scotland For the Year 1953 in Reports of the Department of Health for Scotland and the Scottish Health Services Council 1953, PP 1953-54, xv, Cmd 9107, p. 47.

2. Report of the Department of Health for Scotland For the Year 1950 in Reports of the D.H.S. and the S.H.S.C. 1950, PP 1950-51, xv, Cmd 8184, p. 32.

3. Report of the Department of Health for Scotland For the Year 1953, p. 55.

4. About 2.5 per cent of the institutional population was discharged each year (Report of the Department of Health for Scotland For the Year 1954 in Reports of the D.H.S. and the S.H.S.C. 1954, PP 1954-55, v, Cmd 9417, p. 57).

5. The conversion of Ladysbridge Mental Hospital, Banff, into a mental deficiency institution was in progress by 1955 (Annual Report of the General Board of Control for Scotland For the Year 1955, PP 1955-56, xxii, Cmd 9807, p. 6).

6. Extensions were, for example, erected at Baldovan, Woodlands Home, Cults, and Merchiston House, Renfrew, in the early 1950s (Report of the Department of Health for Scotland For the Year 1953, p. 55).

7. As in the case of the two new pavilions built at Baldovan (ibid., p. 55).

8. D.H.S., S.H.S.C., Mental Deficiency in Scotland: Report by a Sub-Committee of the Standing Medical Advisory Committee (1957), para. 21 [hereinafter cited as Mental Deficiency Report].

9. Ibid., para. 21.

10. Annual Report of the General Board of Control for Scotland For the Year 1955, p. 10.

11. Mental Deficiency Report, para. 18.

12. Annual Report of the General Board of Control for Scotland For the Year 1955, p. 12.

13. The provision for hospital building in 1955-56 was £1,900,000; the amount was to be increased to £2,200,000 in the following year, and to £2,500,000 in 1957-58 (Report of the Department of Health for Scotland For the Year 1955 in Reports of the D.H.S. and the S.H.S.C. 1955, PP 1955-56, xxi, Cmd 9742, p. 53.

14. Some admission units (like that opened at Riccartsbar Mental Hospital, Paisley in 1953) were provided by rearrangement and conversion, and others (including the one hundred bed unit at the

Edinburgh Royal, begun in 1955) were purpose-built (Annual Reports of the Department of Health for Scotland, passim).

15. The Crichton Royal's Ladyfield Unit, and the others which were subsequently opened, have previously been described in chapter 8.

16. The unit at Stratheden was, with 102 beds, one of Scotland's largest psychogeriatric units (Report of the Department of Health for Scotland For the Year 1954, pp. 54-55).

17. Report of the Department of Health for Scotland For the Year 1955, p. 53.

18. Report of the Department of Health for Scotland 1957, p. 43.

19. Ibid., p. 43.

20. S.R.O. HH101/10 (1948-51), N.H.S., Review of the Transitional Arrangements of the Specialist Services, Grading of Specialist and Other Hospital Medical Staffs, Note of Meeting, 15 June 1949.

21. Report of the Department of Health for Scotland For the Year 1949 in Reports of the D.H.S. and the S.H.S.C. 1949, PP 1950, xi, Cmd 7921, Table 2, p. 31. There were 124 specialists in medicine, and 148 in surgery.

22. Only eleven and nineteen specialists were on the S.H.M.O. grade in medicine and surgery respectively in 1949 (ibid., Table 2, p. 31).

23. By 1955, there were 110 psychiatric specialists; sixty-seven consultants and forty-three S.H.M.O.s (Report of the Department of Health for Scotland For the Year 1955, Table 2, p. 58).

24. The expansion in the use of out-patient facilities is discussed later.

25. From 1,759 to 2,633 (M.O.H./D.H.S., Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services (1959), para. 233).

26. Mental Deficiency Report, paras. 37-40.

27. Annual Report of the General Board of Control for Scotland For the Year 1958, PP 1959-60, xviii, Cmnd 892, p. 9.

28. Annual Report of the General Board of Control for Scotland For the Year 1960, PP 1960-61, xviii, Cmnd 1468, p. 11.

29. Report of the Scottish Health Services Council 1953 in Reports of the D.H.S. and the S.H.S.C. 1953, pp. 137-39.

30. Report of the Scottish Health Services Council 1954 in Reports of the D.H.S. and the S.H.S.C. 1954, p. 141.

31. The sub-committee recommended that a simple form of in-service training should be introduced for them (ibid., p. 142).

32. Ibid., p. 142.

33. Report of the Department of Health for Scotland For the Year 1953, p. 61.

34. As in the case of the 1955 campaign in the South-Eastern Region (Report of the Department of Health for Scotland For the Year 1955, p. 63).

35. Report of the Scottish Health Services Council 1953, p. 138.

36. Report of the Department of Health for Scotland 1957, p. 76.

37. Annual Report of the General Board of Control for Scotland For the Year 1955, p. 6.

38. Ibid., p. 8.

39. Anne Digby, From York Lunatic Asylum to Bootham Park Hospital, University of York Borthwick Paper No. 69 (1986), p. 35.

40. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 10.

41. David H. Clark, Administrative Therapy: The Role of the Doctor in the Therapeutic Community (1964), p. 15.

42. Tom Butler, Mental Health, Social Policy and the Law (1985), pp. 171-72.

43. Annual Report of the General Board of Control for Scotland For the Year 1961, PP 1961-62, xviii, Cmnd 752, pp. 7-8.

44. This is discussed later in the chapter.

45. There is some difference of opinion on the subject, however. Ramon states that the Littlemore Hospital, Oxford, was the first in the twentieth century (Shulamit Ramon, Psychiatry in Britain: Meaning and Policy (1985), p. 154), but Hays claims that another English hospital, Warlingham Park, was the pioneer (Peter Hays, New Horizons in Psychiatry (1964), p. 139). But although some hospitals may have begun the liberalisation process earlier than did Dingleton, it is generally accepted (as in Clark, op. cit., pp. 19-20) as the first totally open British mental hospital.

46. Clark, op. cit., p. 19.

47. Ibid., p. 19.

48. Among them were the members of Galashiels and Selkirk Voluntary Association for Mental Health (of which Dr. Bell was the Chairman during the 1950s), which proudly claimed Dingleton as 'the first

mental hospital in the world to adopt the open-door system' (N.L.S. Acc. 7170, Scottish Association for Mental Health [hereinafter cited as S.A.M.H. Papers], Box 7, File 3, Galashiels and Selkirk V.A.M.H., 1956-70).

49. Ramon, op. cit., p. 137.

50. Report of the Department of Health for Scotland For the Year 1954, p. 55.

51. Annual Report of the General Board of Control for Scotland For the Year 1958, p. 8. The reference is undoubtedly to Dingleton.

52. That is, a hospital might be considered 'open-door' if, like the Crichton Royal, it had very few locked wards.

53. Maxwell Jones, The Process of Change (1982), p. 11.

54. Clark, op. cit., p. 93.

55. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 10.

56. Annual Report of the General Board of Control for Scotland For the Year 1958, p. 8.

57. The diminution in patients' aggressive behaviour and the more friendly relationship between staff and patients that the open door engendered was frequently noted by the General Board (as in Annual Report of the General Board of Control for Scotland For the Year 1954, PP 1955-56, xxii, Cmd 9552, p. 7), and by the Department (as in Report of the Department of Health for Scotland For the Year 1954, p. 55).

58. Jones, Social Psychiatry in the Community in Hospitals and in Prisons (1962), pp. x-xi.

59. Ibid., p. 73.

60. Clark, op. cit., p. 45.

61. Report of the Department of Health for Scotland 1956, PP 1956-57, xiii, Cmnd 140, p. 37, and Annual Report of the General Board of Control for Scotland For the Year 1957, PP 1958-59, xvi, Cmnd 546, p. 8.

62. Report of the Department of Health for Scotland For the Year 1955, p. 34.

63. Ibid., p. 34.

64. The developments taking place in O.T. and other therapies are discussed later in this chapter.

65. As in the case of Kingseat Mental Hospital, Aberdeen, these amenities were often provided by voluntary effort (S.A.M.H.

Papers, Box 4, File 1, Aberdeen and North-East Association for Mental Health, 1958-75).

66. Jones, The Process of Change, p. 16.

67. Ibid., p. 16 and Jones, Beyond the Therapeutic Community: Social Learning and Social Psychiatry (1968), p. 4.

68. Jones, The Process of Change.

69. Butler, op. cit., p. 172.

70. Clark, op. cit., p. 15.

71. Annual Report of the General Board of Control for Scotland For the Year 1958, p. 8.

72. Report of the Department of Health for Scotland 1960, Part 1: Health and Welfare Services, PP 1960-61, xvii, Cmnd 1320, p. 77.

73. One Hundred and Thirty-Third Annual Report, For the Year 1945, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 15.

74. Annual Report of the General Board of Control for Scotland For the Year 1958, p. 7. Other jobs included dismantling condemned G.P.O. telephones, repairing sacks and making prefabricated boats.

75. Ibid., p. 7.

76. A survey carried out in mental hospitals and mental deficiency institutions at the end of the 1950s found that less than 2 per cent of the patients who were employed went out to work while living in hospital (Editorial, 'Health Services in Scotland', The Hospital 56, No. 7 (July 1960), p. 533).

77. Annual Report of the General Board of Control for Scotland For the Year 1956, PP 1956-57, xv, Cmnd 212, p. 6.

78. Report of the Department of Health for Scotland 1959, PP 1959-60, xvi, Cmnd 983, p. 37.

79. Editorial, 'Hospital Farms and Gardens', The Hospital 52, No. 6 (June 1956), pp. 316-17.

80. Editorial, 'Health Services in Scotland', The Hospital 56, No. 7 (July 1960), p. 533.

81. Annual Report of the General Board of Control for Scotland For the Year 1958, p. 9.

82. Ibid., p. 9. J. Nixon Browne, M.P., Joint Under-Secretary of State for Scotland, also admitted that while the conditions in many mental hospitals were more cheerful, there remained a lot of old furniture and 'chocolate brown wards' ('Comments on Scottish

Mental Hospitals', The Hospital 52, No. 11 (November 1956), p. 730) [hereinafter cited as Nixon Browne Comments].

83. Of the 20,733 diagnosed patients resident in all mental hospitals at 31 December 1955, for example, no less than 8,552 were suffering from schizophrenic disorders. The next most common diagnosed condition was manic-depression, with 3,038 patients. Of the 11,019 patients admitted to mental hospitals during 1956, 1,847 were schizophrenics and 2,102 were manic-depressives. Syphilis, once responsible for such a mass of incurable mental illness, was by contrast responsible for a mere thirty-two admissions during 1956 (Annual Report of the General Board of Control for Scotland For the Year 1957, Tables M.H.S. 5, pp. 26-27 and M.H.S. 6, pp. 28-29.

84. Annual Report of the General Board of Control for Scotland For the Year 1957, p. 8.

85. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 11.

86. Oral information from Dr. Simon Backett, Edinburgh University Department of Psychiatry, interviewed on 15 May 1987.

87. Report of the Department of Health for Scotland 1961, Part 1: Health and Welfare Services, PP 1961-62, xvii, Cmnd 1703, p. 36.

88. Ibid., p. 36. The borderline between relief and cure, however, is not easily determined.

89. Although as late as 1957 some doctors still regarded insulin coma therapy as the best treatment for some types of schizophrenic disorder (Annual Report of the General Board of Control for Scotland For the Year 1957, p. 8).

90. Table 9:1 gives more detailed figures.

91. In 1955, for example, the incidence of mental hospital admissions in all age groups was 408 (male) and 401 (female) per 100,000 of population; but the figures for those in the over seventy-five category were 1,152 (male) and 1,664 (female) per 100,000 (Annual Report of the General Board of Control for Scotland For the Year 1957, Table M.H.S. 1, p. 22).

92. In both 1956 and 1957, for example, those over sixty-five formed about 22 per cent of all admissions, and 48 per cent of those admitted in the age group were certified (Report of the Department of Health for Scotland 1958, PP 1958-59, xv, Cmnd 697, p. 31).

93. Table 9:1.

94. Since, as the General Board pointed out, patients no longer had to take into account the local authorities' power to recover the cost of maintenance (Annual Report of the General Board of Control for Scotland For the Year 1954, p. 6).

95. The general feeling that the public perception of mental disorder and the mentally disordered had improved, which was shared by the General Board, the Department of Health, voluntary organisations and official investigators into the service was also shared by Nixon Browne, who felt that there had been a great advance in the community's attitude since World War Two (Nixon Browne Comments, p. 730).

96. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 9.

97. In 1956, for example, the number of individuals admitted was, at approximately 9,200, almost 1,000 less than the total number of admissions (Annual Report of the General Board of Control for Scotland For the Year 1956, p. 5).

98. Table 9:2.

99. Voluntary patients were more likely to be readmitted at every stage, and, overall, 38 per cent of voluntary admissions were readmissions, compared to 26 per cent of certified admissions (Annual Report of the General Board of Control for Scotland For the Year 1959, PP 1960-61, xviii, Cmnd 1160, p. 7).

100. Table 9:2.

101. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 11.

102. This is discussed in the following chapter.

103. Table 9:3.

104. In 1956, when the General Board compiled statistics on this, it found that, of those discharged in the year, forty certified patients and 273 voluntary patients had left hospital within a week of admission, and 176 certified patients and 1,884 voluntaries had stayed more than a week but less than a month (Annual Report of the General Board of Control for Scotland For the Year 1957, Table M.H.S. 3, p. 24).

105. Table 9:1.

106. Table 9:3.

107. Of the patients resident at 31 December 1955, 2,459 certified and fifty-seven voluntary patients had been resident for thirty years or more (Annual Report of the General Board of Control for Scotland For the Year 1957, Table M.H.S. 2, p. 23).

Chapter 10: Footnotes

1. The after-care officer was a social worker whose main function was the rehabilitation of special patients. (Annual Report of the General Board of Control for Scotland For the Year 1957, PP 1958-59, xvi, Cmnd 546, p. 6).

2. The 1948 Act enabled education authorities to establish a Y.E.S. and twelve (including those in Glasgow, Edinburgh and Aberdeen) had done so. In the remaining twenty-three areas the Y.E.S. was run by the Ministry of Labour and National Service (S.E.D., Education in Scotland in 1952, PP 1952-53, ix, Cmd 8813, p. 66).

3. James F. Montgomerie, The Handicapped Person: A Report on the Provision of Welfare Services for Handicapped Persons in Scotland (1958), p. 41. The wider impact of the shortage of social workers is described later in the chapter.

4. This adviser was also in charge of the co-ordination of occupational, recreational and social therapy, and aimed to help patients to acquire skills which had practical as well as therapeutic value (Report of the Department of Health for Scotland For the Year 1954 in Reports of the Department of Health for Scotland and the Scottish Health Services Council 1954, PP 1954-55, v, Cmd 9417, p. 56 and Report of the Department of Health for Scotland For the Year 1955 in Reports of the D.H.S. and the S.H.S.C. 1955, PP 1955-56, xxi, Cmd 9742, p. 63).

5. N.L.S. Acc. 7170, Scottish Association for Mental Health [hereinafter cited as S.A.M.H. Papers], Box 4, File 2, Airdrie and District Association for Mental Welfare, 1952, 1959-66.

6. Montgomerie, op. cit., p. 41.

7. James Farndale, The Day Hospital Movement in Great Britain (1961), pp. 337-42.

8. D.H.S., S.H.S.C., Mental Deficiency in Scotland: Report by a Sub-Committee of the Standing Medical Advisory Council (1957), para. 33.

9. In the late 1950s the Crichton Royal had facilities for about a dozen day patients and the Edinburgh Royal and the Southern General Hospital had places for approximately twenty and thirty respectively (Farndale, op. cit., passim).

10. Although the cost of day patients was not generally separately costed, it was believed to be a small proportion of the cost of in-patient treatment (ibid., p. 249).

11. In the year 1954-55, for example, the number of visits made to out-patient clinics in N.H.S. mental hospitals rose from 15,374 to 18,660. There were also a 'great many' visits made to psychiatric clinics in general hospitals (Report of the Department of Health for Scotland For the Year 1955, p. 63).

12. There were forty-seven clinics in the Western Hospital Region in 1957, compared to fifteen, eighteen, seven and four in the South-Eastern, Eastern, North-Eastern and Northern Regions respectively (Report of the Department of Health for Scotland 1957, PP 1957-58, xiv, Cmnd 385, pp. 41-42).

13. Report of the Department of Health for Scotland 1959, PP 1959-60, xvi, Cmnd 983, pp. 39-40.

14. Report of the Department of Health for Scotland 1958, PP 1958-59, Cmnd 697, xv, p. 47.

15. Montgomerie, op. cit., p. 37.

16. D.H.S., S.H.S.C., Mental Health Legislation: Second Report by a Committee Appointed by the Council (1959), para. 28.

17. Montgomerie, op. cit., p. 38.

18. Ibid., pp. 38-39.

19. Report of the Department of Health for Scotland 1956, PP 1956-57, xiii, Cmnd 140, p. 55.

20. Ibid., p. 55.

21. S.A.M.H. Papers, passim.

22. The Parents' Association opened a senior centre in Rutherglen in 1961 (ibid., Box 5, File 2, Cambuslang and District Voluntary Care Committee, 1960-75).

23. Report of the Department of Health for Scotland 1959, p. 36.

24. S.A.M.H. Papers, Box 6, File 2, East Stirlingshire Voluntary Association for Mental Welfare, 1960-69.

25. Montgomerie, op. cit., p. 40.

26. Annual Report of the General Board of Control for Scotland For the Year 1956, PP 1956-57, xv, Cmnd 212, p. 9. The Board suggested that an increase in the guardians' allowance might help.

27. The number of defectives under guardianship in their own homes or with unrelated guardians rose from 1,587 in 1938 to 2,558 in 1954 but by the end of 1960 it had fallen to 2,442 (Annual Reports of the General Board of Control for Scotland, passim).

28. It fell from 524 in 1950 to 256 in 1960 (Report of the Department of Health for Scotland For the Year 1950 in Reports of the D.H.S. and the S.H.S.C. 1950, PP 1950-51, xv, Cmd 8184, p. 42 and Annual Report of the General Board of Control for Scotland For the Year 1960, PP 1960-61, xviii, Cmnd 1468, p. 6).

29. The Association in 1952 sent a questionnaire on under-fives to local authorities and to the General Board, but no useful

information could be deduced from it (S.A.M.H. Papers, Box 2, File 1, Minutes etc., 29 June 1951-11 December 1954) [hereinafter cited as Minutes 1951-54].

30. Montgomerie, op. cit., pp. 35-36.

31. Ibid., p. 36. The numbers awaiting admission to N.H.S. institutions could not be given without reference to all the Regional Hospital Boards who administered the institutions since, as noted later, no central register was kept. But (as noted in the last chapter) even the R.H.B.s' figures were unlikely to be complete, since many waiting lists were effectively closed. The incomplete evidence obtained from twenty-nine local authorities, however, suggested that there were in 1956-57 over five hundred mental defectives in the community who were awaiting admission to institutions (ibid., p. 35).

32. L.H.A.s were in 1947 informed that the Secretary of State did not expect them to make immediate or elaborate arrangements for ascertainment (D.H.S., The Welfare Needs of Mentally Handicapped Persons: Report by a Committee of the Scottish Advisory Council on the Welfare of Handicapped Persons (1957), para. 6) [hereinafter cited as Welfare Needs Report].

33. The division of function was maintained when, in September 1958, responsibility for the maintenance of patients in the first three categories was transferred to the National Assistance Board (Annual Report of the General Board of Control for Scotland For the Year 1958, PP 1959-60, xviii, Cmnd 892, p. 12), but was finally ended when under the terms of the Mental Health (Scotland) Act 1960 responsibility for the maintenance of boarded-out defectives also became a N.A.B. function.

34. Montgomerie, op.cit., p. 67.

35. Sixteen local authorities had made such arrangements (Report of the Department of Health for Scotland For the Year 1948, PP 1948-49, xvii, Cmd 7659, p. 40).

36. As was done in 'many' cases (Report of the Department of Health for Scotland 1958, p. 32).

37. M.O.H./D.H.S., Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services (1959), para. 744 [hereinafter cited as the Younghusband Report].

38. Even at a progressive hospital like Dingleton, for example, the P.S.W.'s office was in an isolated part of the hospital, and doctors made little use of her (Maxwell Jones, Beyond the Therapeutic Community (1968), p. 3).

39. The Chief Medical Officer of the Department of Health remarked in 1956 that many mental hospitals had repeatedly advertised for P.S.W.s, but without success (H. Kenneth Cowan, 'After-Care and Rehabilitation', in S.A.M.H., Mental Health: Proceedings of a Conference Held ... [on] 23-25 March 1956, p. 48).

40. Ibid., p. 48. Three hospitals had more than one P.S.W., four had one, four had a part-time P.S.W., one 'shared' a P.S.W. with the local authority, one had an almoner doing the work, and fourteen did not have a P.S.W.

41. The Working Party on local authority social workers, in its 1959 report, found that, excluding those working in child guidance and those shared with hospitals, there were only two qualified P.S.W.s in Scottish health departments (Younghusband Report, para. 464).

42. Cowan, op. cit., p. 48.

43. Report of the Department of Health for Scotland For the Year 1948, pp. 20-21.

44. Montgomerie, op. cit., p. 39.

45. Whole-time health visitors were confined to cities and towns. In rural areas the health visitor was usually the district nurse and midwife (Report of the Department of Health for Scotland For the Year 1953 in Reports of the D.H.S. and the S.H.S.C. 1953, PP 1953-54, xv, Cmd 9107, p. 42). The Department in 1948 acknowledged that lack of staff meant that health visitors would have little time for duties which were outside their traditional sphere (Report of the Department of Health for Scotland For the Year 1948, p. 21).

46. Report of the Department of Health for Scotland For the Year 1956, p. 52.

47. Report of the Department of Health for Scotland 1960, Part 1: Health and Welfare Services, PP 1960-61, xvii, Cmnd 1320, p. 42 [hereinafter cited as Health and Welfare 1960]. Aberdeen had begun to give its health visitors intensive courses in 'mental hygiene' some years before, and a scheme similar to that in Edinburgh had recently begun in Dundee.

48. Report of the Department of Health for Scotland 1961, Part 1: Health and Welfare Services, PP 1961-62, xvii, Cmnd 1703, p. 38 [hereinafter cited as Health and Welfare 1961].

49. Report of the Department of Health for Scotland For the Year 1956, p. 52.

50. Aberdeen in 1959 began a sustained attempt to promote mental health and to reduce maladjustment, delinquency, anti-social behaviour and neurosis, and health visitors took a leading part in the public education aspects of the programme (Report of the Department of Health for Scotland 1959, p. 54).

51. H.P. Tait, A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974, p. 131.

52. Health and Welfare 1961, p. 38.

53. A survey in 1962 suggested that health visitors were still largely concerned with maternity and child health and T.B. work (S.H.H.D., Health and Welfare Services in Scotland, Report for 1962, PP 1962-63, xix, Cmnd 1996, p. 41) [hereinafter cited as Health and Welfare 1962].

54. The delay in the issuing of the Working Party's report was previously described (with reference to its recommendations on special education) in chapter 8. Its recommendations regarding an expansion of hostels, clubs and other community facilities for the mentally disordered (Welfare Needs Report, paras. 22-26 and 38-39) also encountered the rather muted response of D.H.S. Circular 17/1957 (S.R.O. HH61/56 (1954-55), Education of Handicapped Pupils, Reports of the Advisory Council on Education in Scotland, Comments by Department of Health for Scotland, etc.).

55. Montgomerie, op. cit., p. 71.

56. More precisely, L.H.A. spending rose from £3,833,000 in the financial year ended 15 May 1952 to £7,559,000 in the financial year ended 15 May 1962 (Health and Welfare 1962, p. 38).

57. Ibid., p. 38. Spending on domestic help rose by 116 per cent, and spending on vaccination and immunisation by 220 per cent, in the ten year period.

58. Health and Welfare 1960, p. 40.

59. Spending on the L.H.A. mental health services was £235,000 in 1951-52, and £236,000 in 1961-62, a percentage change, in real terms, of minus 25 (Health and Welfare 1962, p. 38). But the latter figure did not include spending on the maintenance of boarded-out defectives, which, as already noted, had been transferred to the National Assistance Board in 1960.

60. Health and Welfare 1960, p. 39.

61. The gap in the Association's records in the 1940s and early 1950s means that the reason for the change of name is not clear.

62. S.A.M.H. Papers, Minutes 1951-54.

63. Ibid., Box 7, File 7, Hamilton Local Voluntary Association for Mental Health, 1953-63. The views of 'the ladies' in Hamilton were also influenced by the L.E.A. 'takeover' (after the 1945 Education Act) of the function of providing junior occupation centres.

64. S.A.M.H. Papers, Box 2, File 4, Minutes etc., 17 January 1959-29 November 1960. The Association's grant from the General Board, as noted in chapter 4, was £600 in 1928-29.

65. This information about the Association's activities is from S.A.M.H. Papers, Box 2, Files 1-4, Minutes etc., 29 June 1951-29 November 1960, passim).

66. S.A.P.H.C. was by 1956-57 active in Glasgow, Aberdeen, Dumbartonshire, Dumfries, Edinburgh, Perth and Lanarkshire (Montgomerie, op. cit., p. 43). S.A.M.H. refers to S.A.P.H.C. branches in a number of other areas - including Inverness, Stirling/Clackmannan, Greenock and Fife - in its records in the later 1950s (S.A.M.H. Papers, Boxes 4-9, Papers Relating to Affiliated Local Voluntary Associations, passim).

67. S.A.M.H. Papers, Box 5, File 2, Cambuslang and District Voluntary Care Committee, 1960-75. The information was contained in a cutting from an (unnamed) Rutherglen newspaper, 2 December 1960.

68. Montgomerie, op. cit., p. 66.

69. The Secretary and Treasurer of S.A.M.H. (James Robb) asserted that when he first heard of S.A.P.H.C.'s formation he wrote to the new association suggesting a meeting, since he did not think that there was room for two groups in the mental health field. He received no reply. He later contacted S.A.P.H.C. again, and two joint meetings were held. But S.A.P.H.C.'s determination to proceed with the formation of local groups irrespective of whether S.A.M.H. affiliates were active in the area apparently led to a cooling of relations (S.A.M.H. Papers, Box 8, File 3, Lanark and District Voluntary Association for Mental Health, 1957-64, Letter from Robb to W. Rule, District Offices, Lanark, 11 December 1957).

70. Ibid., Robb to Rule.

71. Ibid., Box 5, File 7, A Volume of Minutes and Associated Papers of Dumfries and District Local Voluntary Association for Mental Health, 1949-62. The outcome of these efforts is not clear.

72. Ibid., Box 5, File 2, Cambuslang and District Voluntary Care Committee, 1960-75.

73. In Greenock in 1959, for example, some members of the public who gave donations to S.A.P.H.C. apparently did so while under the impression that they were contributing to S.A.M.H. S.A.M.H. activists in the town felt that the major problem was that the new Association's name was confusingly like their own (ibid., Box 7, File 6, Greenock and District Voluntary Association for Mental Health 1959-75).

74. F.O.R.A.K., for example, arranged outings for patients, helped in the hospital library, provided reading material and helped run the beauty parlour (ibid., Box 4, File 1, Aberdeen and North-East Association for Mental Health, 1958-75).

75. The Superintendent of Hartwood Hospital, Lanark, in the late 1950s and early 1960s appeared to be extremely unco-operative, and rebuffed the attempts at liaison made by voluntary groups in the area. His attitude did not appear to be based on an objection to interference by unelected voluntary workers, since he also refused to collaborate with the local authority (ibid., Box 4, File 2, Airdrie and District Association for Mental

Welfare, 1952, 1959-66; Box 5, File 4, Coatbridge and District Voluntary Association for Mental Health, 1959-66; and Box 7, File 7, Hamilton Local Voluntary Association for Mental Health, 1953-63). This, however, must be balanced against the many cases in which superintendents encouraged voluntary participation, as in the case of the hospital visiting groups already described.

76. Montgomerie, op. cit., p. 67.

Chapter 11: Footnotes

1. The Russell Committee stressed that allowing certifiable patients to enter hospital voluntarily on the grounds of 'expediency and alleged public interest' was illegal (D.H.S., Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws (1946), PP 1945-46, xiii, Cmd 6834, para. 281 [hereinafter cited as the Russell Report].

2. In 1901 7.6 per cent of the Scots population was over sixty years of age: by 1941 the figure was 13 per cent (One Hundred and Thirty-First Annual Report, For the Year 1943, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 13.

3. But whose relatives were willing for them to enter hospital.

4. One Hundred and Thirty-Fifth Annual Report of the Royal Edinburgh Hospital For the Year 1947, p. 11.

5. It was, by the 1940s, rare for lunatics to be placed under guardianship on a Sheriff's order; the alternative, the sanction of the General Board of Control, was the usual method of placement. But the placement of an adult defective who was classed as 'feeble-minded' or as a 'moral imbecile' under guardianship required an order under the terms of the 1913 Act.

6. As the General Board argued (Annual Report of the General Board of Control for Scotland For the Year 1954, PP 1955-56, xxii, Cmd 9552, p. 6).

7. Shulamit Ramon, Psychiatry in Britain: Meaning and Policy (1985), p. 266.

8. Public indifference was a recurring theme in the records of local voluntary associations affiliated to the Scottish Association for Mental Health (N.L.S. Acc. 7170, Scottish Association for Mental Health [hereinafter cited as S.A.M.H. Papers], Boxes 4-9, Papers Relating to Affiliated Local Voluntary Associations, passim).

9. As S.A.M.H., which closely monitored media coverage of mental health issues, noted in 1954 (S.A.M.H. Papers, Box 2, File 1, Minutes etc., 29 June 1951-11 December 1954).

10. Annual Report of the General Board of Control for Scotland For the Year 1954, p. 6.

11. One Hundred and Twenty-First Annual Report, For the Year 1937, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 11.

12. Ibid., p. 11. Professor Henderson had also written a book on the subject before the war, Psychopathic States (1939).

13. The Russell Report, paras. 82 and 89-90.

14. Ibid., paras. 88 and 16.

15. Ibid., para. 117.

16. Ibid., paras. 302-303.

17. Ibid., paras. 269-70.

18. Ibid., paras. 163-65.

19. Ibid., para. 468. As already stated in note 5, two categories of the mentally defective - the 'feeble-minded' and 'moral imbeciles' - could not, when over twenty-one, be dealt with (sent to an institution or placed under guardianship) except with the authority of a judicial order. The other categories - 'idiots' and 'imbeciles' - could be dealt with, at any age, without an order, provided that their parents consented and that the General Board's sanction was obtained. None, however, could be dealt with on their own application, and even when a defective was dealt with on the parents' application it had to be supported by two medical certificates.

20. Ibid., paras. 373, 470 and 477.

21. Ibid., paras. 420-24.

22. Ibid., para. 17.

23. Ibid., Reservations, pp. 118-21. The recommendation regarding the treatment of non-volitional patients without a judicial order had previously been put forward by a combined committee of the Royal Medico-Psychological Association, the Psychological Section of the British Medical Association and the Psychological Committee of the Royal College of Physicians, London.

24. Cyril Greenland, 'One Hundred Years of Scottish Lunacy Legislation', Public Health 72, No. 1 (April 1958), p. 152.

25. One Hundred and Twentieth Annual Report of James Murray's Royal Asylum Perth [for the year ended 31 March 1947], p. 12.

26. Greenland, op. cit., p. 152.

27. One Hundred and Thirty-Second Annual Report, For the Year 1944, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, p. 10.

28. One Hundred and Thirty-Fourth Annual Report, For the Year 1946, of the Royal Edinburgh Hospital for Mental and Nervous Disorders, pp. 4-5.

29. One Hundred and Twentieth Annual Report of James Murray's Royal Asylum Perth [for the year ended 31 March 1947], p. 12.

30. S.R.O. HH101/959 (1945-46), N.H.S., General Policy, Functions of General Board of Control, D.H.S. Memorandum, 'N.H.S., Mental Health Aspects of the Service and the Functions of the General Board of Control for Scotland', 21 March 1946.

31. Ibid., D.H.S. Memorandum ... 21 March 1946.

32. Including its recommendation that 'asylums' should in future be designated as 'mental hospitals'.

33. Report of the Department of Health for Scotland 1959, PP 1959-60, xvi, Cmnd 983, p. 34.

34. The Royal Commission is discussed later in the chapter.

35. D.H.S., The Law Relating to Mental Illness and Mental Deficiency in Scotland: Proposals for Amendment (1955), PP 1955-56, xxxvi, Cmd 9623, paras. 4-6.

36. Ibid., paras. 7-11 and 14.

37. Ibid., para. 35. The doctor, however, would be required to answer specific questions designed to ascertain the type of provision, training and accommodation which would be most appropriate for each case.

38. Ibid., para. 36.

39. Ibid., para. 39.

40. Ibid., para. 1.

41. Greenland, op. cit., p. 153.

42. Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957 (1957), PP 1956-57, xvi, Cmnd 169, paras. 7 and 22 and chapter 5, passim.

43. Ibid., para. 42 and paras. 312-17.

44. These tribunals, it recommended, should be organised on a regional basis and include medical and non-medical members appointed by the Lord Chancellor (ibid., paras. 438-54).

45. Ibid., para. 377.

46. Ibid., para. 18 and paras. 142-43.

47. Ibid., para. 58 and paras. 788-91.

48. Ibid., chapter 10, passim.

49. Ibid., paras. 185-98.

50. Ibid., paras. 338-58.

51. Tom Butler, Mental Health, Social Policy and the Law (1985), p. 160.

52. In the debate on the report in the House of Commons Dr. Edith Summerskill pointed out that psychiatric labels were subjective

classifications which could be misused, and that the suffragettes were seen as behaving abnormally at the time (ibid., p. 181, and Ramon, op. cit., p. 253).

53. D.H.S., S.H.S.C., Mental Health Legislation: Report by a Committee Appointed by the Council (1958), paras. 1-3.

54. Ibid., paras. 5-10. The Committee proposed that these units should be established both under the N.H.S. and the penal system.

55. Ibid., para. 11.

56. Ibid., para. 13.

57. The Medical Commissioners, the Committee believed, were obliged to look at problems from two different and often incompatible standpoints; in its pungent analogy, they were asked to play both the referee, in matters affecting patients' interests, and the centreforward in the Secretary of State's mental health team (ibid., para. 15).

58. Ibid., paras. 32-37.

59. Ibid., para. 11 and paras. 29-30.

60. Ibid., para. 50.

61. D.H.S., S.H.S.C., Mental Health Legislation: Second Report by a Committee Appointed by the Council (1959), para. 4.

62. Ibid., para. 46.

63. Ibid., para. 8.

64. It did, however, recommend that the Department's mental health division should be strengthened (ibid., para. 49).

65. Ibid., para. 48.

66. Ibid., paras. 49 and 46.

67. The Scottish Health Services Council Report for 1959, pp. 6-7.

68. Report of the Department of Health for Scotland 1958, PP 1958-59, xv, Cmnd 697, p. 32. While the decision about the type of patients who were admitted informally was left to the discretion of the superintendent of the institution, the authorities were told that it would be especially suitable for low-grade juvenile defectives. Much, however, depended on the patient's home conditions, and informal admission was not advised if the patient was likely to be withdrawn from treatment or training by 'irresponsible' parents.

69. Table 11:3 shows the number of informal mentally deficiency admissions. In addition, forty-nine children in an institution

in the North-East were reclassified to informal status during 1958 (ibid., p. 32).

70. Report of the Department of Health for Scotland 1959, p. 34.

71. Report of the Department of Health for Scotland 1960, Part 1: Health and Welfare Services, PP 1960-61, xvii, Cmnd 1320, p. 32 [hereinafter cited as Health and Welfare 1960]. The Annual General meeting of the World Federation of Mental Health, which had as its theme 'Action for Mental Health' was in 1960 held in Edinburgh (S.A.M.H. Papers, Box 8, File 2, Kirkcaldy and District Mental Health and Welfare Association, 1960-75).

72. As was remarked of the English Act of 1959 (Editorial, 'Aspects of Mental Health', Public Health 80, No. 3 (March 1966), p. 106).

73. Table 11:1.

74. 4,895 certified patients and 4,193 voluntary patients were reclassified to informal status during 1961, and a further 2,735 patients had been reclassified by the end of 1962 (Annual Report of the General Board of Control for Scotland For the Year 1961, PP 1961-62, xviii, Cmnd 1752, Appendix, Table II, pp. 12-13, and S.H.H.D., Health and Welfare Services in Scotland, Report for 1962, PP 1962-63, xix, Cmnd 1996, p. 34 [hereinafter cited as Health and Welfare 1962].

75. The numbers are shown in Table 11:2; see also Figure 11:1.

76. Table 11:1.

77. The numbers are shown in Table 11:2; see also Figure 11:1.

78. Table 11:3. Since the General Board's last report was for 1961, and the Scottish Home and Health Department's reports did not provide mental deficiency statistics, only the immediate impact of the 1960 Act can be shown in the table.

79. Health and Welfare 1962, pp. 36-37.

80. Table 11:4.

81. Annual Report of the General Board of Control for Scotland For the Year 1960, p. 6.

82. Section 32 provided that an application for compulsory admission could be made in respect of a person who was already an informal patient.

83. The procedures for compulsory admission and reception into guardianship were dealt with in Part IV of the Act, paras. 23-53 passim.

84. Section 45 provided a 'priority list' of relatives; spouse, child, father, mother, brother or sister, grandparent, grandchild, uncle or aunt, nephew or niece. The 'nearest relative' was the first

one on the list who was caring for the patient. If no relative had been caring for the patient, the first existing relative on the list would make the application.

85. Mental Health Officers corresponded to the Duly Authorised Officers of the previous structures. They took over those officials' function of setting in motion the procedure for compulsory admission to hospital or reception into guardianship where this was necessary and where the patient's relatives were unable or unwilling to take action (section 7(1)(C) and section 26). While the M.H.O.'s statutory duties were confined to the compulsory procedures, the Act implied that he or she would also carry out the local authority's duties relating to the health and welfare of the mentally disordered, such as the supervision of patients under guardianship. The Act did not make any stipulations regarding the qualifications or experience of M.H.O.s but, especially if they undertook a variety of functions, a social worker appeared to be most apt.

86. Section 31 provided for admission on the sole authority of an 'emergency' medical recommendation, which authorised the patient's detention for up to seven days.

87. Section 28(1). These powers were discretionary, but section 28 (3) provided that the Sheriff could not refuse an application without giving the parties concerned a hearing.

88. The granting of an order for a mental defective was, as has previously been described, already a judicial rather than an administrative act.

89. Section 23.

90. The General Board's functions in respect of the State Hospital, therefore, were transferred to a State Hospital Management Committee appointed by the Secretary of State (S.H.H.D., Health and Welfare Services in Scotland, Report for 1963, PP 1963-64, xv, Cmnd 2359, p. 68 [hereinafter cited as Health and Welfare 1963].

91. The constitution, functions and relationships of the M.W.C. were defined in sections 2-5 of the Act.

92. 'Mental Health (Scotland)Act 1960', The Hospital 58, No. 4 (April 1962), p. 254. Sir Hugh had been a Commissioner of the Board since 1936.

93. The others were the provision of residential accommodation, the appointment of M.H.O.s, the exercise of functions in respect of those under guardianship, the ascertainment of defectives not of school age, and the provision of any anciliary or supplementary services.

94. Section 8(2).

95. D.H.S.,S.H.S.C., Mental Health Services of Local Health Authorities: Report by the Standing Committee on Local Authority Services (1961), passim.

96. D.H.S. Circular 75/1960, Mental Health (Scotland) Act 1960: Mental Health Services, 20 October 1960.

97. Health and Welfare 1962, p. 84.

98. During 1962 approval was granted for the provision of a day nursery and assessment centre for mental defectives in Glasgow, occupation centres in Glasgow, Alloa and Edinburgh and hostels in Edinburgh and Aberdeen. Three nurseries and four occupation centres opened in the following year (ibid., p. 36, and Health and Welfare 1963, p. 32).

99. The Regulations drawn up by the Secretary of State included the Mental Health (Guardianship) Scotland Regulations 1962, which set out the powers and duties of guardians and the supervisory duties of L.H.A.s and the Mental Health (Forms) Scotland Regulations 1962, which prescribed the forms required for compulsory procedures. A booklet There is a New Outlook in Mental Health was widely circulated to voluntary associations (Health and Welfare 1962, p. 33). The provisions of the Act which affected L.E.A.s, including the redefinition of 'ineducable' described in chapter 8, were explained in S.E.D. Circular 461, Mental Health (Scotland) Act 1960, 19 April 1961.

100. Table 11:2.

101. Table 11:2.

102. Report of the Department of Health for Scotland 1961, Part 1: Health and Welfare Services, PP 1961-62, xvii, Cmnd 1703, p. 35.

Conclusion: Footnotes

1. Editorial, 'The Scottish Version', The Hospital, 56, No. 3 (March 1960), p. 169.

2. There were 17,908 known lunatics (including mentally defective children in training schools) on 1 January 1908. There were, at the end of 1960, 20,303 mental patients, 8,492 certified mental defectives and 520 'informal' defectives. 3,523 lunatics were admitted to institutions in 1908: 12,760 mental patients and 593 mental defectives were admitted to institutions in 1960 (Annual Reports of the General Board of Commissioners in Lunacy for Scotland and General Board of Control for Scotland, passim).

3. Charles Cromhall Easterbrook, The Chronicle of Crichton Royal 1833-1936 (1940), p. 528.

4. Quoted in ibid., p. 297.

5. One Hundred and Fourth Annual Report of the Royal Edinburgh Asylum For the Year 1916, p. 14.

6. Report of the Department of Health for Scotland 1961, Part 1: Health and Welfare Services, PP 1961-62, xvii, Cmnd 1703, p. 36.

7. Annual Report of the General Board of Control for Scotland For the Year 1961, PP 1961-62, xviii, Cmnd 1752, p. 7.

Bibliography

Primary Sources

I Volumes of Public General Acts and Statutes, 1857-1960.

II Volumes of Parliamentary Debates, 1908-60.

III Departmental Papers.

S.R.O. DD files relating to administrative schemes under the 1929 Local Government Act.

S.R.O. ED 28 files relating to special education.

S.R.O. HH61 files relating to local authority health and welfare functions.

S.R.O. HH65 files relating to medical services in the years before the N.H.S.

S.R.O. HH101 files relating to the introduction of the N.H.S. and subsequent policy and administration.

S.R.O. MC: Minute Books of the General Board of Commissioners in Lunacy for Scotland and General Board of Control for Scotland.

IV Command and Other Official Papers.

Annual Reports of the General Board of Commissioners in Lunacy for Scotland, 1900-13.

Annual Reports of the General Board of Control for Scotland, 1914-38, 1954-61.

Annual Reports of the Local Government Board for Scotland, 1905-18.

Annual Reports of the Scottish Board of Health, 1919-28.

Annual Reports of the Department of Health for Scotland, 1929-61.

Annual Reports (Health and Welfare Services) of the Scottish Home and Health Department 1962, 1963.

Annual Reports of the Scottish Health Services Council, 1949-63.

Annual Reports of the Committee of Council on Education in Scotland, 1919-38.

Annual Reports on Education in Scotland, 1939-61.

Report of the Royal Commission on the Care and Control of the Feeble-Minded, Vol. VIII, 1908, xxxix (Cd 4202).

Report of the Royal Commission on the Poor Laws and Relief of Distress, 1909, xxxvii (Cd 4499).

Royal Commission on the Poor Laws and Relief of Distress, Report on Scotland, 1909, xxxviii (Cd 4922).

Royal Commission on the Poor Laws and Relief of Distress, Appendix, Volume VI, Minutes of Evidence... [Scottish Witnesses]..., 1910, xlvi (Cd 4978).

Ministry of Reconstruction, Local Government Committee, Report on Transfer of Functions of Poor Law Authorities in England and Wales, 1917-18, xviii (Cd 8917).

Scottish Board of Health, Consultative Council on Medical and Allied Services, Interim Report, A Scheme of Medical Service for Scotland, 1920, xvii (Cmd 1039).

Ministry of Health, Report of the Committee on Administration of Public Mental Hospitals, 1922, viii (Cmd 1730).

Report of the Royal Commission on Lunacy and Mental Disorder, 1926, xiii (Cmd 2700).

Scottish Office, Proposals for Reform in Local Government in Scotland and in the Financial Relations Between the Exchequer and Local Authorities, 1928, xix (Cmd 3135).

Board of Education and Board of Control, Report of the Mental Deficiency Committee. London: H.M.S.O., 1929.

Report of the Departmental Committee on Sterilisation, 1933-34, xv (Cmd 4485).

Department of Health for Scotland, Report of the Committee on the Scottish Health Services, 1935-36, xi (Cmd 5204).

Scottish Office, Report of the Committee on Scottish Administration, 1936-37, xv (Cmd 5563).

Department of Health for Scotland, Report of the Scottish Departmental Committee on Nursing, 1937-38, xii (Cmd 5866).

Social Insurance and Allied Services: Report by Sir William Beveridge, 1942-43, vi (Cmd 6404).

Department of Health for Scotland, Report of the Committee on Post-War Hospital Problems in Scotland, 1942-43, iv (Cmd 6472).

Ministry of Health/Department of Health for Scotland, A National Health Service, 1943-44, viii (Cmd 6502).

Scottish Education Department, Education (Scotland) Bill. Explanatory Memorandum by the Secretary of State for Scotland, 1944-45, x (Cmd 6602).

Department of Health for Scotland, Report of the Committee on the Scottish Lunacy and Mental Deficiency Laws, 1945-46, xiii (Cmd 8260).

Scottish Education Department, Pupils With Mental or Educational Disabilities: A Report of the Advisory Council on Education in Scotland, 1951-52, x (Cmd 8401).

Scottish Education Department, Pupils Who Are Maladjusted Because of Social Handicaps: A Report of the Advisory Council on Education in Scotland, 1951-52, x (Cmd 8428).

Scottish Education Department, The Administration of Education for Handicapped Pupils: A Report of the Advisory Council on Education in Scotland, 1951-52, x (Cmd 8432).

Department of Health for Scotland, The Law Relating to Mental Illness and Mental Deficiency in Scotland: Proposals for Amendment, 1955-56, xxxvi (Cmd 9623).

Report of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-57, 1956-57, xvi (Cmnd 169).

Department of Health for Scotland, Scottish Health Services Council, Mental Deficiency in Scotland: Report by a Sub-Committee of the Standing Medical Advisory Council. Edinburgh: H.M.S.O., 1957.

Department of Health for Scotland, The Welfare Needs of Mentally Handicapped Persons: Report by a Committee of the Scottish Advisory Council on the Welfare of Handicapped Persons. Edinburgh: H.M.S.O., 1957.

Department of Health for Scotland, Scottish Health Services Council, Mental Health Legislation: Report by a Committee Appointed by the Council. Edinburgh: H.M.S.O., 1958.

Department of Health for Scotland, Scottish Health Services Council, Mental Health Legislation: Second Report by a Committee Appointed by the Council. Edinburgh: H.M.S.O., 1959.

Ministry of Health/Department of Health for Scotland, Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services. London: H.M.S.O., 1959.

Scottish Education Department, Degrees of Mental Handicap: Report of the Working Party on Standards of Ascertainment for Scottish Schoolchildren. Edinburgh: H.M.S.O., 1961.

Department of Health for Scotland, Scottish Health Services Council, Mental Health Services of Local Health Authorities:

Report by the Standing Advisory Committee on Local Authority Services. Edinburgh: H.M.S.O., 1961.

Scottish Home and Health Department, Scottish Health Services Council, Medical Services for Child Guidance: Report by a Sub-Committee of the Standing Medical Advisory Council. Edinburgh: H.M.S.O., 1962.

Mental Welfare Commission, A Duty to Care: An Account of the Work of the Commission Between 1962 and 1972. Edinburgh: H.M.S.O., 1972.

V Official Circulars.

S.E.D. No. 105, The Education and Care of Mentally and Physically Defective Children, 1 September 1937.

S.E.D. No. 38, Education (Scotland) Act 1945, 12 September 1945.

D.H.S. 147/1945/S.E.D. No. 45/1945, School Medical Service, 7 November 1945.

S.E.D. No. 300, The Education of Handicapped Pupils, 21 March 1955.

S.E.D. No. 331, The Schools (Scotland) Code 1956, 18 June 1956.

D.H.S. 7/1958, Informal Admission of Patients to Mental Deficiency Institutions, 4 September 1958.

S.E.D. No. 384/D.H.S. 80/1958, Working Party on the Provisions for Handicapped Children, 4 September 1958.

D.H.S. 75/1960, Mental Health (Scotland) Act 1960: Mental Health Services, 20 October 1960.

S.E.D. No. 461, Mental Health (Scotland) Act 1960, 19 April 1961.

VI Reports etc. of Other Statutory Bodies.

Edinburgh Corporation Education Committee's Annual Reports on the Work of Schools and on the Progress of the Committee, 1929-42.

Glasgow Corporation's Annual Reports on the Child Guidance Service, 1946-47, 1953-54, 1956-57.

Mitchell Library (514709), Minutes of Glasgow District Lunacy Board, 1901-14.

VII Hospital Archives

Annual Reports of Aberdeen Royal Asylum/Mental Hospital, 1905-39.

Annual Reports of Edinburgh Royal Asylum/Mental Hospital, 1905-47.

Annual Reports of Glasgow Royal Asylum/Mental Hospital, 1907, 1908, 1910, 1911, 1913-15, 1919, 1931-47 (the other reports are missing from the Glasgow Health Board Archive).

Annual Reports of Glasgow District Asylum, Gartloch, 1905-16.

Annual Reports of Glasgow District Asylum, Woodilee, 1905-19.

Miscellaneous Annual Reports of James Murray's Royal Asylum, Perth, and Govan District Asylum, Hawkhead.

Mitchell Library (514709), Minutes of Gartloch Asylum Committee, 1901-14.

Mitchell Library (514709), Minutes of Woodilee Asylum Committee, 1901-14.

VIII Papers of Voluntary Organisations.

National Library of Scotland, Acc. 7170, Papers of the Scottish Association for Mental Health (and of its predecessor bodies, the Scottish Association for Mental Welfare and Scottish Association for Mental Hygiene), 1921-76.

IX Newspapers and Journals.

British Journal of Educational Psychology.

British Journal of Psychology.

Dundee Courier and Advertiser.

Eugenics Review.

Glasgow Herald.

Poor Law and Local Government Magazine.

Public Health.

The Hospital.

The Scotsman.

The Times.

The Year Book of Education.

Secondary Sources

I Unpublished Theses and Papers.

Ewins, D., The Origins of the Compulsory Commitment Provisions of the Mental Health (Scotland) Act 1959. M.A. thesis, University of Sheffield, 1974.

Rice, F.J., Madness in Industrial Society. Ph.D. thesis, University of Strathclyde, 1981.

Presly, A.S., From Madhouses to Mental Hospitals: Does History Repeat Itself? A paper based on a lecture given on the occasion of the 200th anniversary of Sunnyside Royal Hospital, Montrose, on 23 June 1981 (from the author).

Rhind, Margaret B., One Hundred Years of Mental Health: Woodilee Hospital 1875-1975 (Mitchell Library).

II Articles.

Blackden, Stephanie, 'The Board of Supervision and the Scottish Parochial Medical Service, 1845-95', Medical History 30, No. 2 (April 1986), 145-72.

Blythman, Marion, Review of Profound Mental Handicap by C. McHellier, S.A. Magowan and L.A. Angus, Scottish Educational Review 15, No. 1 (May 1983), 74-75.

Crowther, M.A., 'Family Responsibility and State Responsibility in Britain Before the Welfare State', Historical Journal 25, No. 1 (March 1982), 131-41.

Dow, Derek A., '"Lost to his country as well as to his friends": Voluntary Hospitals and Working Men', Scottish Industrial History 8.1 (1985), 31-45.

Editorial, 'Aspects of Mental Health', Public Health 80, No. 3 (March 1966), 106-107.

Editorial, 'The Mental Health Revolution', Public Health 86, No. 2 (January 1972), 49-52.

Farrall, Lyndsay A., 'The History of Eugenics: A Bibliographical Review', Annals of Science 36, No. 2 (March 1979), 111-23.

Grob, Gerald N., 'Mental Retardation and Public Policy in America: A Research Agenda', History of Education Quarterly 26, No. 2 (Summer 1986), 307-13.

Jackson, R.N., Review of Special Education in Scotland by W.B. Dockrell, W.R. Dunn and A. Milne (eds.), Scottish Educational Review 11, No. 1 (May 1979), 80-82.

Jones, Kathleen, 'Administrative Problems in the Mental Health Services', Public Health 78, No. 1 (November 1963), 11-18.

Mackenzie, Donald, 'Eugenics in Britain', Social Studies of Science 6, No. 4 (September 1976), 499-532.

McGovern, Constance M., 'The Myths of Social Control and Custodial Oppression: Patterns of Psychiatric Medicine in Late Nineteenth Century Institutions', Journal of Social History 20, No. 1 (Fall 1986), 3-23.

'Mental Health (Scotland) Act 1960', The Hospital 58, No. 4 (April 1962), 254.

Robinson, Daniel L., 'The Scottish Enlightenment and its Mixed Bequest', Journal of the History of Behavioural Sciences 22 (April 1986), 171-77.

Pilkington, T.L., 'Public and Professional Attitudes to Mental Handicap', Public Health 87, No. 3 (March 1973), 61-66.

Rice, Francis J., 'Class and the Treatment of the Insane in Mid-Nineteenth Century Scotland', Scottish Labour History Society Journal No. 20 (1985), 43-58.

Rice, Francis J., 'The Origins of an Organisation of Insanity in Scotland', Scottish Economic and Social History 5 (1985), 41-56.

Rollin, H.R., 'Are Mental Hospitals Really Necessary?', Public Health 90, No. 2 (January 1976), 49-52.

Searle, G.R., 'Eugenics and Politics in Britain in the 1930s', Annals of Science 36, No. 2 (March 1979), 159-69.

Swanson, Ian, Review of 'Freedom to Grow: Sister Marie Hilda's Vision of Child Guidance' by Sister Jude, Scottish Educational Review 14, No. 1 (May 1984), 67-68.

III Printed Books.

(A few of these books might be considered to be primary sources, but the decision has been taken to list all books alphabetically.)

Abel-Smith, Brian, The Hospitals 1840-1948: A Study of Social Administration in England and Wales. London: Heinemann, 1964.

Aberdeen Association of Social Service, Aberdeen Association of Social Service 1870-1970. Aberdeen: A.A.S.S., 1971.

Ashdown, M. and Brown, S.C., Social Services and Mental Health: An Essay on Psychiatric Social Workers. London: Routledge and Kegan Paul, 1953.

Blacker, C.P., Voluntary Sterilisation. London: Oxford University Press: Humphrey Milford, 1934.

Butler, Tom, Mental Health, Social Policy and the Law. Basingstoke: Macmillan, 1985.

Carmont, James, The Crichton Royal Institution, Dumfries. Leicester: Raithby, Lawrence and Co. Ltd., De Montford Press, 1896.

Catford, E.F., The Royal Infirmary of Edinburgh 1929-1979. Edinburgh: Scottish Academic Press, 1984.

Checkland, Olive and Lamb, Margaret (eds.), Health Care as Social History - The Glasgow Case. Aberdeen: Aberdeen University Press, 1982.

Clare, Antony, Psychiatry in Dissent: Controversial Issues in Thought and Practice. London: Tavistock Publications, 1976.

Clark, David, Administrative Therapy: The Role of the Doctor in the Therapeutic Community. London: Tavistock Publications, 1964.

Digby, Anne, Madness, Morality and Medicine: A Study of the York Retreat 1796-1914. Cambridge: Cambridge University Press, 1985.

Dockrell, W.B., Dunn, W.R. and Milne, A. (eds.), Special Education in Scotland. Edinburgh: S.C.R.E., 1978.

Doerner, Klaus, Madmen and the Bourgeoisie: A Social History of Insanity and Psychiatry. Oxford: Basil Blackwell, 1981.

Easterbrook, Charles Cromhall, The Chronicle of Crichton Royal 1833-1936. Dumfries: Courier Press, 1940.

Edgerton, Robert B., The Cloak of Competence: Stigma in the Lives of the Mentally Retarded. Berkeley: University of California Press, 1967.

English, John, and Martin, F.M. (eds.), Social Services in Scotland. Edinburgh: Scottish Academic Press, 1979.

Farndale, James, The Day Hospital Movement in Great Britain. Oxford: Pergamon Press, 1961.

Farrall, Lyndsay A., The Origins and Growth of the English Eugenics Movement 1865-1925. Ann Arbor, Michigan: University Microfilms International, 1970.

Ferguson, Thomas, Scottish Social Welfare 1864-1914. Edinburgh: E. and S. Livingston Ltd., 1958.

Finnane, Mark, Insanity and the Insane in Post-Famine Ireland. London: Croom Helm, 1981.

Foucault, Michel, Madness and Civilisation: A History of Insanity in the Age of Reason. London: Tavistock Publications, 1967.

Freeman, Hugh, and Farndale, James (eds.), Trends in the Mental Health Services. Oxford: Pergamon Press, 1963.

Gibson, John, The Thistle and the Crown: A History of the Scottish Office. Edinburgh: H.M.S.O., 1985.

Goffman, Erving, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. Harmondsworth: Penguin Books, 1968.

Hearnshaw, L.S., A Short History of British Psychology 1840-1940. London: Methven and Co. Ltd., 1964.

Hearnshaw, L.S., Cyril Burt, Psychologist. London: Hodder and Stoughton, 1979.

Henderson, D.K., The Evolution of Psychiatry in Scotland. Edinburgh: E. and S. Livingston Ltd., 1964.

Ingleby, David (ed.), Critical Psychiatry: The Politics of Mental Health. Harmondsworth: Penguin Books, 1981.

Jones, Greta, Social Hygiene in Twentieth Century Britain. London: Croom Helm, 1986.

Jones, Kathleen, Lunacy, Law and Conscience 1744-1845: The Social History of the Care of the Insane. London: Routledge and Kegan Paul, 1955.

Jones, Kathleen, Mental Health and Social Policy 1845-1959. London: Routledge and Kegan Paul, 1960.

Jones, Maxwell, Beyond the Therapeutic Community: Social Learning and Social Psychiatry. New Haven: Yale University Press, 1968.

Jones, Maxwell, Social Psychiatry in the Community, in Hospitals and Prisons. Springfield, Illinois: Charles C. Thomas, 1962.

Jones, Maxwell, The Process of Change. Boston: Routledge and Kegan Paul, 1982.

Montgomerie, James F., The Handicapped Person: A Report on the Provision of Welfare Services for Handicapped Persons in Scotland. Edinburgh: Scottish Council of Social Service, 1958.

Morris, Pauline, Put Away: A Sociological Study of Institutions for the Mentally Retarded. London: Routledge and Kegan Paul, 1969.

Murray Royal Hospital Perth 1827-1977 [no place, company or date of publication].

Pottinger, George, The Secretaries of State for Scotland 1926-76. Edinburgh: Scottish Academic Press, 1979.

Pritchard, D.G., Education and the Handicapped 1760-1960. London: Routledge and Kegan Paul, 1963.

Ramon, Shulamit, Psychiatry in Britain: Meaning and Policy. London: Croom Helm, 1985.

Robins, Joseph, Fools and Mad: A History of the Insane in Ireland. Dublin: Institute of Public Administration, 1986.

Rosen, Marvin, Clark, Gerald R., and Kivitz, Marvin S., The History of Mental Retardation: Collected Papers, Volumes 1 and 2. Baltimore: University Park Press, 1976.

Scottish Council of Social Service, The Welfare of the Disabled in Scotland. Edinburgh: S.C.S.S., 1958.

Scull, Andrew T., Madhouses, Mad-Doctors and Madmen: The Social History of Psychiatry in the Victorian Era. London: Athlone Press, 1981.

Scull, Andrew T., Museums of Madness: The Social Organisation of Insanity in Nineteenth Century England. London: Allen Lane, 1979.

Searle, G.R., The Quest for National Efficiency. Oxford: Basil Blackwell 1971.

Sedgwick, Peter, Psychopolitics. London: Pluto Press, 1982.

Skultans, Vieda, English Madness: Ideas on Insanity 1580-1890. London: Routledge and Kegan Paul, 1979.

Skultans, Vieda, Madness and Morals: Ideas on Insanity in the Nineteenth Century. London: Routledge and Kegan Paul, 1975.

Sutherland, Gillian, Ability, Merit and Measurement: Mental Testing and English Education 1880-1940. Oxford: Clarendon Press, 1984.

Szasz, Thomas, Ideology and Insanity: Essays on the Psychiatric Dehumanisation of Man. London: Calder and Boyars, 1973.

Tait, H.F., A Doctor and Two Policemen: The History of Edinburgh Health Department 1862-1974 [no place or company of publication] 1974.

Timms, Noel, Psychiatric Social Work in Great Britain 1939-1962. London: Routledge and Kegan Paul, 1964.

Treacher, Andy, and Baruch, Geoff, Psychiatry Observed. London: Routledge and Kegan Paul, 1978.

Webster, Charles (ed.), Biology, Medicine and Society 1840-1940. Cambridge: Cambridge University Press, 1981.